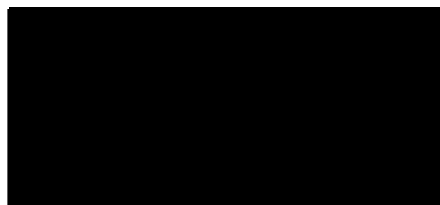


The social construction of gender in informal
care: a discourse analytic approach to
investigating community care practitioners'
talk

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Abstract

The world of informal care has become a fruitful ground for investigation particularly in relation to establishing the contextual variables of the population of carers and the recipients of care. Research has highlighted that significantly more women than men are engaged in the informal delivery of physical and personal care. A common assertion is that caring is seen predominantly as women's work and that much of the decision making in community care is based upon such assumptions. Many empirical studies in the field of informal care rely on traditional approaches, which confine the focus of study to uncovering such assumptions and in so doing adopt a realistic perspective on responses. However, such studies prove problematic in that they treat language as a transparent and neutral medium for transmitting information and fail to acknowledge that responses are situationally specific, variable and deployed for particular purposes. Instead this thesis investigates the range of discourses that formal service providers use when talking about informal caregivers. It demonstrates how these discourses attribute a range of characteristics to informal care, which serves to pathologise it as a gendered activity.

Six social care managers and six district nurses were interviewed to discuss the nature of informal care and the method of discursive psychology was used, which draws on the tradition of conversation analysis as well as Bakhtinian and Foucauldian ideas. Instead of viewing language as a transparent medium, this study sees the interplay between language and social processes and demonstrates how it both reflects and shapes informal care.

This study reveals the range of cultural, historical and professional resources drawn upon to characterise and therefore constitute informal caregiving. It demonstrates how the informants produce versions of informal care, which draws heavily on a prior carer identity. The research reveals among other things how informal care by women is constructed as normative and informal care delivered by men as potentially deviant. The research offers a fresh insight into the social construction of gender within social institutions and makes an important contribution to the existing corpus in gender studies. In addition the findings have important implications for policy and practice in informal care and significant issues have relevance to social work, nurse education and continuing professional development.

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Introduction

Care in or by the community has been a recurrent theme since the 1980s, not just in the UK but world wide. Often referred to as a conception of right wing political parties, community care policy has risen on the back of concerns regarding rising health care expenditure, and the debate about how far the state should go, in providing social and health services. The introduction of health and welfare policy reforms has produced a rich vein for research in a number of key areas primarily concerning the products of private and public interventions.

An important focus for research and academic debate, broadly speaking, is the way that contemporary social and health care policy has constructed the domestic sphere as a desirable substitute for state intervention. And with this, the incorporation of the family in the service sector as the willing providers of care. Building on the concept of “traditional family values” and all that that implies *vis-à-vis*, moral obligations, the new directions in policy contrive, either directly or indirectly, to make women responsible for the health of the family.

Contemporary critical analysis has successfully highlighted the way in which caring, generally and specifically, is a gendered occupation both in the formal and informal locations.

However, the fact that caring is constructed as a gendered occupation, as evidenced by many academic authors, is not at question. This research seeks to investigate how this construction is produced and communicated through the accounts of practitioners. In an attempt to lay bare the assumptions regarding gender, which permeate discourse, this thesis examines the range of linguistic resources used by district nurses and social care managers, which function to naturalise the role of women in the provision of the “family” model of care.

This thesis is reported in eight chapters. The first chapter presents an historical overview of the movement from institutional care to community care. Discussion centres on the various factors that have shaped this shift. Chapter two provides a review of the literature concerning informal care. The main themes covered include the identity of informal caregivers and the activities that they are engaged in. The impact that caregiving has on the health and well being of carers is discussed and in the light of this attention is paid to the factors that motivate informal carers to commence and to continue caregiving. The way that formal service providers respond to informal carers is also overviewed.

Chapter three provides a discussion on qualitative methodologies and works towards the use of discursive psychology as a means of uncovering the ways in which objects are constructed through language as a set of social practices. The key gatekeepers to services for informal carers are identified as district nurses and social care managers. The research questions are identified and centre on the how the evaluative practices of the two sample groups construct informal care as a gendered activity. Six from each of the sample groups are interviewed separately and the data analysed by utilising a blend of conversation and discourse analysis.

Chapter four presents the analysis of data from the perspective of how the informants construct caregiving as an essentially female labour and manage this by referring to the conventional stock of knowledge on gender. At the same time the analysis focuses on the linguistic techniques used by the informants to protect “face” and thus minimise the potential to avoid negative evaluations.

Chapter five is concerned with the construction of the male identity and how this mitigates against involvement in informal caregiving. Again the informants achieve this by drawing

from a range of commonsense ideologies, which preclude men from informal care. The conversational practices are analysed as a means of investigating the variability and contradiction in accounts.

Chapter six looks at how success in informal care is judged according to the occupational remits of the two sample groups. The district nursing informants drew strong comparisons between “good” informal care and clinical nursing proficiency, while the repertoire of the social care managers identified informal care as case management. Chapter seven focuses on how assessment is constructed as an impartial and scientific event, which is separate from the assessor and the potential implications that this has for informal caregivers. Chapter eight brings the thesis to a close and sets out the conclusions of the research study and the potential implications for education and policy as well as for further application of the research methodology presented.

Chapter One

An evolving model of care

1.0 Chapter introduction

Contemporary health and social care policy has generally been conceptualised within a historical framework with many accounts relating directly to issues of funding and organisation. However, as Foucault (1972) suggests, life cannot be grasped from a single perspective and general theory should be avoided. It is therefore not the intention of this chapter to provide a complete over-view of the various critiques of welfare, as they are available elsewhere (see for example Doyal 1984; Klein 1995; 2001; Baggott 2004). The principle aim is to look to “the speculative possibilities” for community care policy, (Rorty 1986, pg: 48) and in so doing, avoid confinement of the thesis within a particular political theory.

There is necessarily a selective focus considering the very detailed and complex nature of the theoretical areas. In order to avoid repetition of other texts, this chapter therefore is limited in the detail it provides, considering initially the chronological events in health care policy. The discussion broadens to reveal the multiplicity of factors that have shaped community care policy and how such policies have been maintained and developed. The critiques explored in this chapter centre on Marxist, Feminist and Foucauldian perspectives. Illich’s thesis on iatrogenesis, provides a further view of the development of contemporary healthcare.

1.1 Historical perspectives on community care.

Major changes in the provision of modern health care have taken place over the last decade and this has fuelled considerable research and academic commentary. As the focus of this thesis in some way centres on the consequences of the changing ideology of health care, historical issues are therefore explored in order to better understand the background to this change.

Since the 1980s policy makers have become increasingly aware of a number of factors, which carry with them the potential for impact on the provision of health care. As mentioned earlier, this concern has in the main, been global. Twigg et al (1990) pinpoint the economic imperative to reduce health care costs as countries and particularly the UK are faced with a changing demographic profile, which predicts higher expenditure in caring for an older population. In addition technological advances in medical and surgical techniques further contribute to the escalating cost and ultimately the increasing expectation of society regarding the availability of treatments and the quality of care.

This policy shift in the UK is a far cry from the newly established system of the National Health Service with its emphasis on, as Allsop (1984) points out, the provision of health services available without charge on the determination of need by professional service providers. From its inception, professionals in the NHS were given *carte blanche* to make clinical decisions within fairly elastic financial limits, shaping and directing services as they went. As it was widely felt that the ill health of the population could be “conquered” and that ultimately the cost for health care would fall, the government attributed for the inception of the NHS was prepared to fund consumption through the taxation system.

However, ideas began to change soon after, as it became apparent that greater health care spending did not equate with a greater level of health among the population. This has continued through the decades as we can see from the Public Expenditure Statistical Analyses (2002-2003) which identifies the total spending on health care per capita at 1,132 GBP in England compared to 1,347 GBP in Scotland. However, for its increased spending on health care, Scotland does not enjoy increased levels of health, with infant mortality higher and life expectancy reduced (HSQ17).

Moreover, there was a common belief that the government had severely under-estimated the total cost of salaries and wages in the provision of the new welfare system. Subsequently cost containment became an increasing feature of policy as the “financial innocence” of the early principles ended (Klein 1995). Increasingly concerns were aired regarding the demands for health care, which fundamentally, were driven by the service providers. As Bevan complained to ministers: “the doctors had secured too great a degree of control over hospital management committees, and were pursuing a perfectionist policy without regard to the financial limits which had necessarily to be imposed on this service as on other public services” (Public Records Office pg: 104).

This concern was initially managed by reducing capital expenditure on hospitals, a strategy that lasted until the early 1970s. However, the government was able to do very little towards limiting the professional generation of demand. As Klein (1995) comments, “the governments were on a financial escalator” due to the role of doctors as sole agents in the determining need and ultimately, policy. Furthermore, in the post-war period the production and availability of new technologies and drugs created the public perception of medicine as

literally, the panacea to all ills. Such expectations were and still remain a significant factor in the increasing consumption of health care. The knock-on effect of this on funding and expenditure cannot be missed.

Despite the widespread support for publicly funded health care, commentators have suggested that there was a degree of political reluctance to increase taxation to better support the service, no political party being keen to associate with higher taxation (Klein 1995). To compound matters there was confusion and conflict regarding the issue of whether the NHS was indeed under-funded or perhaps over-funded (Allsop 1984). However, a report by Abel-Smith and Timuss (1956) concluded that it was probably more a case of under-funding. The recommendations led the Government towards capital investment in the form of improvements to the deteriorating hospitals.

This was to be a short-lived confidence and with the political commitment to reducing public expenditure, a new culture was emerging in response to calls for greater rationality and efficiency within the service. The NHS had been branded paradoxically as both “spend-thrift” and “penny-pinching”. Initially the concern of the policy makers was to control the size of the NHS budget but not to oversee how it was spent, however, questions began to be asked about both the effectiveness of the NHS at both the general and individual level.

This stemmed in part from a developing notion among the growing body of commentators concerning the actual efficacy of modern medicine (see for instance Illich 1976; Navarro 1978; McKeown 1979). However, the high expectations of the consumer’s pointed to the improbability of a reduction in demand for health care. Decision-makers therefore were

forced to strike a balance between extending the range and complexity of the services and limiting in some way professional intervention.

In addressing this tension, professional aspirations had to be tempered against funding constraints. In answer, an enhanced management strategy was evolving which would focus on achieving the “value for money” which had so far alluded the policy makers. The driving force behind this new paradigm was Sir Roy Griffiths, the then managing director of Sainsbury’s supermarket chain. Commissioned to produce his assessment of the NHS (DHSS 1983) by the government of the time (Conservative), he diagnosed “institutional stagnation” and proposed as its remedy, the adoption of a management structure with the goals of providing effective leadership and satisfying the “consumers” of health care (Klein 1995).

Importing the ideology of the marketplace into an organisation described by Bevan (1961) as “the hallmark of a civilised society” caused some revulsion particularly at the application of management tools, transferred from the profit-making sector and used to measure such illusive concepts as clinical performance, efficacy and impact. This feature represented a distinguishing challenge to the medical profession who saw the recommendations, not surprisingly, as a serious threat to their clinical autonomy and power.

The reforms that immediately followed the Griffiths Report heralded, in a sense, the “professionalisation” of fiscal control with the implementation of criteria from management theory. The tradition in the NHS had been one of the determination of need by clinicians, but this had its draw-backs as Sir Keith Joseph (1972 pg: 72) had earlier pointed out: “Doctors can be remarkably selective in choosing the ills they regard worthy of treatment”.

The introduction, from the profit-making culture of consumer needs and wants into the equation were fundamentally, an attempt to change the culture in the NHS. Consumer orientation as a concept had previously been unused in health care and stemmed from the idea that services could successfully be shaped and moulded in line with consumer demand. This mechanism would be used to target funding in the areas where demand was greater, not as it had previously been provided, based on the interests, which individual doctors wished to pursue. As Klein (1995) suggests, Griffiths sought to mobilise consumer power as a means of reducing professional power. This orientation would be tempered with clinical assessment tools, such as QALY's (Quality Adjusted Life Years) that would measure the "cost-benefit" of treatments and procedures through the application of criteria to judge whether they would yield positive patient outcomes.

This philosophy may have dampened professional domination but it did nothing to control expenditure. On the contrary, it had created a demand-led spending explosion that was particularly evident in the rush for nursing and residential home places. Margaret Thatcher, as Prime Minister (1993) recognised that "the NHS had become a bottomless financial pit" and in answer to this problem, pursued strategies to change its structure and or, system of finance.

Several options were debated but in the end the government decided on the creation of the "internal market" within the NHS whereby the funding for patient treatment would be held by the GP in the primary sector. Health care could be purchased from other agencies, on behalf of each individual patient, who would be "allowed" to remain in their own homes if they wished, for as long as possible. GPs would therefore hold the budget for their group of patients and purchase the necessary services and procedures from any number of providers,

privately or otherwise. There was also to be an emphasis on the quality of patient care; which would be based on needs assessment, “good” case management and better value for money. The government *White Papers Working for Patients* (1989) and *Caring for People* (1989) formalised this model.

1.2 Ideology of care “in” the community.

In the description of NHS formation and the issues arising as a result, it comes as no surprise that the acute sector in health care has enjoyed “pole position” when it comes to funding. Acute services have generally been first in line in the battle for resources, with the long stay sector remaining as low priority, due in part to the inarticulacy of the user group (Klein 1995). a paradigm shift was on the horizon with the emergence of a different ideology. Community care was slowly gaining momentum, which may or may not have stemmed from an explicit ideology but was none-the-less accepted as being coherent.

Ideas about the nature and location of health care began to surface. A new “enlightened” approach was developing which seemed to be fuelled in some senses, by humanitarian concerns. As large-scale institutions had predominated as the location of care, in the main due to capital investment and expansion in the early NHS, this had become a blueprint for the mode of care. Important studies such as that by Townsend (1962) had brought to public notice the unacceptable conditions inside such large-scale institutions that effectively acted as “warehouses” for the elderly and people with special needs. A new model which shifted the care of vulnerable people to smaller community based institutional settings would, it was thought, secure an improvement in the quality of care, achieve greater equity in the distribution of resources and provide an improved package of provision for each geographical

area. As Finch (1990 pg: 131) observes, “the community was seen as the location of care, but the provision of facilities and services was still largely assumed to be the responsibility of public authorities”. In this move did not equate to less state service provision but merely altered the boundaries. Despite these concerns Symonds and Kelly (1998) suggest that this strategy did work to bring the marginalized into the community.

Raymond and Williams (1983) suggest that the word “community” is a corner stone in Western culture. For Symonds and Kelly (1998) “community” finds its base in agricultural and industrial capitalism as a form of resistance to deprivation and poverty. However, as a concept it is “imagined” as a supportive and secure location, usually in the East end of London or in villages in the country and peopled by individuals sharing the same values and culture. It conjures up “golden age” images of what life was like “before”. But as Symonds and Kelly highlight, the “before” was a location of subjectivity and oppression. Women and “foreigners” knew their place and men were “masters in their own home” (Symonds and Kelly 1998 pg: 14). Indeed the authors refer to “the community” as a dream place and one that is necessarily gendered.

1.3 Ideology of individualism.

From the perspectives considered so far, it is clear that successive governments have been eagerly looking for new and innovative methods of regulating health care expenditure in the face of infinite expansion. Numerous documents have been commissioned which look to ameliorate disease by shifting the emphasis from the treatment of acute illness to that of prevention (DHSS 1976; 1977; 1981; 1989; 1999). This is representative of the acceptance that fiscal control in the NHS is doomed to failure and that a more cost-effective strategy

might be found in the manipulation of demand through regulating health care expenditure by reducing the need for curative medicine.

The characteristics of demand manipulation find their philosophical bases in the idea that the individual can and should bear some responsibility for safeguarding and maintaining his/her own health. This strategy is representative of the ideology, which places the responsibility for health within the confines of the private sphere, implying, according to Crawford (1977) self-responsibility, self-reliance and self-discipline. For Doyal (1983) these are precepts of the state apparatus, and they serve to reinforce the message that while the role of the state had been to engineer a healthy population through social and medical means, its input is now to be tightly limited. Within this new emphasis the role of service providers such as district nurses, health visitors and social workers was to encourage individuals to make healthy choices. Further evidence of a discourse of individualism and self-responsibility was also to be found in the Children Act (1989) where the emphasis lay on assisting families to maintain their responsibility in the care of their children.

1.4 Health and the State.

Drawing for a moment from the Marxist critique of the health service (although a detailed analysis is beyond the scope of this thesis), commentaries such as that of Doyal (1983), Navarro (1979) and Allsop (1984) highlight how the development of capitalism has influenced social and health policy. This approach contends that health care must be seen as part of the capitalist mode of production. The struggle for a healthier society, or labour force, is necessary to ensure “the survival of the economic system” (Navarro 1976 pp: 197). To illustrate this, the commentators refer to the early and middle parts of the 19th Century when

the general health status of the population was so bad that it interfered with productivity levels. In addition a substantial section of the productive populace had been removed as a consequence of both the First and Second World Wars. Profit accumulation was therefore hindered and it is this force, in particular, which provided the impetus for a universally funded, state organised health and social welfare system. This historical perspective can be measured against a more contemporary history in which we have seen a huge decline particularly in the manufacturing industry and an increase in technology, hence the heightened unemployment levels. We can conclude therefore that the imperative to increase the productivity of the workforce no longer exists when there is a marked surplus of labour.

From a Marxist perspective, the elected government is said to represent the needs of ruling class (to a greater or lesser extent) and will produce and enact policies, which strengthen the position of the dominant group. The goals of the welfare state, while seen initially to reduce the inequalities associated with capitalism, paradoxically functions *for* capitalism in the maintenance of labour resources (Gough 1979; Alcock 1996).

The intention here is to demonstrate how social and health policy is determined according to the needs of the state and not merely as a response to the needs of the population. Although there is a requirement for health and physical efficiency to be maintained at a reasonable level, it is not however, necessary to increase investment in areas which do not yield a direct benefit for capital. In applying Marxist theory to community care policy we can see it as an ideological move designed to reduce the economic pressure on capital.

1.5 Foucauldian analysis.

While Marxist analysis conceptualises systemised health care within a functional framework for its relationship with capital, the post-structuralist perspective of Foucault can be used to transcend the political dimensions. Foucault's work is concerned with power and its relationship to all modern forms of administration, pivoting on the idea that health and social care do not merely serve the needs of the economy as suggested by Marx, but is used as an apparatus for the expression of power. In *Discipline and Punish* (1977) Foucault describes carceral reforms of the late eighteenth century, which recognised for the first time the utility in the monitoring, and surveillance of individuals whose behaviour warranted correction.

Surveillance, he argues, has been perfected over the last two centuries as a subtle tool, assisted by the development of registers, case histories and record keeping. With techniques of monitoring populations that are perceived as being "all-seeing", as in Bentham's prison design, the Panopticon, the subject of surveillance internalises the discipline and corrects "deviant" behaviour (Turner 1992; Sarup 1993). As such, these techniques have great utility in the way that they allow activities to be scrutinized and recorded at minimal cost, while at the same time creating the perception that all behaviours or thoughts can be seen and monitored. It is at this point that surveillance becomes a more effective means of discipline than imprecise absolute power.

In Foucault's work entitled *The Birth of the Clinic* (1976) the development of institutionalised medicine is examined to reveal its collusion with the disciplinary society. Foucault illustrates how medicine rendered the body an object of knowledge and thus a target of power through the process of pathologising behaviour and classifying diseases. For

Foucault power lies in the ability to define and sanction, and as an institution medicine has become a mode of surveillance, regulation and definition. The body of Foucault's work highlight how social institutions such as schooling, medicine, psychiatry and social work form parts of the disciplinary society which in a sense binds the individual with "mental chains" (Sarup 1993 pp: 63). We are all observed or are under the "gaze" through a number of administrative machines, contemporary systemised welfare and its associated professions being only part.

Types of surveillance, particularly in the area of health care continue to expand throughout areas that have traditionally been viewed as the private sphere. For example, one would normally consult health professionals only in times of ill health. However, activities such as health promotion have emerged recently which have created an apparatus for exercising of power in the private and otherwise healthy lives of individuals. Further, doctors and nurses in the area of primary care are under contractual obligation to maximise their surveillance of their patient list by offering advice on maintaining health and encouraging participation in health promotion strategies. Moreover the strategies used attempt to avoid bio-medical reductionism by acknowledging the social, cultural and economic concomitants of health, most of which had previously been considered irrelevant. It would appear from this then that medicine has responded to challenges traditionally thought to be from the political Left in an attempt to address the consequences of industrial capitalism. the Foucauldian analysis reveals that the multi-factorial perspective in health care also serves to make the subject more visible by broadening the "gaze".

To restate, for Foucault power does not emanate from a given point but is the product of all social relations. This view differs from Marx, who holds that power is the property of specific

classes or institutions that subordinate other classes in the service of the economy. Health care therefore is viewed not as a production relation but as a power relation.

1.6 Ideology of care “by” the community.

The creation of the NHS has been an extremely important feature of the twentieth century with its declared aims to provide a universal system of health care, which is available to all regardless of age, class, sex, occupation and geographical location. However, resourcing such a comprehensive system has proved difficult and successive governments have sought to address the fiscal issues through changes to both structure and process. As noted elsewhere, the impetus towards community care has been steadily growing and differing models of care have emerged over time. However, it was not until 1981 that strategies for care by the community became an explicit theme. For instance:

The primary sources of support and care for elderly people are informal and voluntary...It is the role of public authorities to sustain and, where necessary, develop – but never to displace – such support and care. Care *in* the community must increasingly mean, care *by* the community.

(Cmnd 8173 para: 1.9, original emphasis)

This evidences the marked shift in emphasis away from care in the community to care by the community as a result of its apparent reflection of the values of financial prudence, moral superiority and self-reliance in the domestic domain. These combined values visible again in 1985 in the following statement:

Community care is a matter of marshalling resources, sharing responsibilities and combining skills to achieve good-quality modern services to meet the actual needs of real people, in ways which those people find acceptable and in places which encourage rather than prevent normal living. (DHSS 1985, para: 3)

The above quotations provide pertinent examples of how policies proposing the restriction of state provision can be justified, through appeals to human morality, emphasising that citizens should regard such values as entirely reasonable. By couching statements in terms, which allude to the “common good”, this strategy is thus used to give moral legitimacy to political reforms and in so doing, “bring off” a consensus across society. The reference to community care as a policy shift designed to cap public expenditure on residential care is avoided (Lewis & Glennerster 1996). Furthermore, the modifications to social and health care policy occur without overt reference to informal caregivers as the main providers of care.

Specific reference to informal carers as actors in health and social care did not surface until the *Griffiths Report* of 1988. The main points concerned how carers could “be helped with their onerous responsibilities” and more importantly, how they could be included in the care planning process (Griffiths 1988, para: 4.13). But the picture that was emerging was one in which the family featured heavily as care provider. Community care was being translated into “family care” as a means of restricting public expenditure. To return to the Marxist analysis of health care we can see from Walker,

The state occupies a dual role in relation to community care: it may provide direct support where this is absolutely necessary, but its main concern is to ensure the

continuance of the prime responsibility of the family for the support and care of its own members. (Walker 1983, pg: 121)

State ideology supporting a familial model of care is strengthened by the acknowledgement in policy, of the role of informal carers in health and social care provision. To this end proposals were made for carer inclusion in care planning with the government White Paper *Caring for People* (DoH 1989) and the *NHS and Community Care Act* (DoH 1990), both of which extend to the concept of carers having their own needs assessed. However, these policies have a very indirect focus on informal care.

1.7 Post Griffiths

Klein (2001) comments that as soon as the new model within the NHS appeared, the process of modifying it started again. Thus the NHS is described as a “self-inventing institution” (Klein 2001, pg: 182). The post Griffiths period saw the emergence of a new vocabulary, which promoted the notion of consumer rights or at the very least, consumer expectation. Publications such as the *Citizen’s Charter* (HMSO 1991) and the *Patients Charter* (DoH 1991) evidenced further movement towards mimicking a market paradigm. Managerialism expanded with an increasing array of performance indicators designed primarily as management tools but latterly employed as a means of giving the consumers of health care services information. The “mixed economy” of care was intended to reduce the role of the State in the provision of care by commissioning other care providers (Baggott 2004). However, the commissioning process was bureaucratic and complicated and tended towards fitting the needs of service users into pre-existing provision. Henwood (1995) comments that there was considerable variation in the experience of users and carers, some local authorities

and healthcare Trusts being more responsive than others. It appears that despite efforts to decentralise and to devolve decision-making, legislation was needed to address this variation.

The publication *Caring About Carers: A national strategy for carers* (DoH 1999) was the first with a specific focus on informal carers. It offered formal acknowledgement of the numbers involved and confirmation of the fact that few are in receipt of adequate service support. As a remedy it suggests that policy will now reflect the explicit needs of carers *visa vis*, involvement in planning services, ring-fenced provision for respite care, pension rights and statutory inclusion in health needs assessment.

In terms of needs assessment, it has long been the duty of professionals at “street level” to determine the nature and scope of interventions aimed at the passive client. However, the last decade has seen a change in the philosophy of needs assessment occurring as a response to the consumerist paradigm in health and social care (Smith 1988). Moving from the inherent paternalism in the professional determination of need, to give way to a concept of partnership between client and service provider (Croft & Beresford 1993). Along with this is the idea that those involved in informal care, in exercising their role as patient advocate, should be included in the partnership (Simpson 1997).

Commentators such as Twigg (1992) and Parker and Lawton (1994) point out that despite the recommendations, the burden of care had not been rendered significantly lighter and little evidence exists to support the idea that such a philosophy was transferred to actual practice. Indeed, confusion remained in the way that formal service providers saw their responsibilities to their informal counterparts, a theme, which will be developed in the following chapter. The proposals for a *National Strategy for Carers* to some extent addressed some of the

conceptual difficulties in as much as it accorded status to those providing care. However, with the emphasis on supporting carers to continue caring, the Strategy did not give carers the right to a separate assessment. This was facilitated by *The Carers (Recognition of Services) Act 1995* afforded carers the right to their own assessment if they engaged in providing a “substantial” level of care on a regular basis. Moreover the Act replaced *Invalid Care Allowance* with the *Carers Allowance*. However, as Unell (1996) points out, the Act may have raised the profile of informal caregiving but the cost constraints which local authorities work within mean that services are targeted at those most in need. This means that caregivers compete for resources against a range of other potential service users. Furthermore, Myers and McDonald (1996) question how effective assessment is in improving the actual outcomes for carers.

Government documents *Towards a Primary Care-Led NHS* (NHSE 1994) and *Designed to Care: Renewing the National Health Service in Scotland* (DoH 1997) suggested additional restructuring of health service funding in the primary care sector with the promise of “patient involvement in making more decisions about their own care” (DoH 1997, pg:7). The *Strategy for Carers in Scotland* (Scottish Executive 2000 pg: 2) acknowledged the “vital contribution made to society by the many unpaid carers in Scotland who look after relatives or friends” and thus ring fenced 10 million pounds to be shared among local authorities to enable “flexible and quality services” to meet carers needs. The recommendations of the Strategy related to six key priorities:

- Promotion of new and more flexible services for carers including respite care
- Better and more targeted information for carers at a national level
- The specific needs of young carers

- National standards for carers services
- Carer's legislation to allow carer's needs to be met more directly
- Monitoring by the Scottish Executive of the performance of health and social work services in supporting carers.

(SPICe briefing 2003)

Accordingly carers are now considered “key partners” in the provision of services. *The Community Care and Health (Scotland) Act 2002* provided the legislative backing for further changes to community care services. The Act sought to address the distinction between the health care and social care service delivery of personal care. While health care has traditionally been provided free at the point of delivery, social care is means tested. Therefore an individual requiring a social care assessment would previously have been charged for personal care that was delivered under the terms of their care package. According to Robson (2003) local authorities are concerned about the cost of implementing the *Community Care and Health (Scotland) Act 2002* and are considering the rationing of services. In addition this Act gives caregivers the legal status as partners in care. Formal service providers are under obligation to fully involve them in the assessment of need for the recipient of care and to assess the resources carers need to allow them to continue in their caregiving role.

Talk of under funding in health and social care services has existed for as long as the Welfare State (Baggott 2004). As a means of addressing the shortfall local authorities have begun to prioritise and rank according to need. Thus services may be targeted towards those in greatest need. As a result of the financial squeezes service users are diverted away from costly residential care meaning that care homes increasingly care for those with very complex needs who are more costly to care for (Baggott 2004). This created a gap, which was filled

largely by the independent sector in the provision of intermediate services seeking to prevent admission to institutional care.

1.8 The increasing complexity of informal care.

Domiciliary-based care of late has been the focus of further strategic shift. While initially thought more suitable for ageing and disabled people with long-term needs, the primary care setting is increasingly used as a location for more complex and intensive care (Kirk & Glendinning 1998). Conditions which have traditionally required acute intervention in the hospital setting such as myocardial infarction, fractures, strokes and intravenous therapies are now being treated in the home, in some areas (Marks 1991; 1992). As a result, informal carers are now carrying out tasks and procedures that were previously located within a professional remit. There is the expectation therefore that familial carers will take responsibility for skilled technical care on the basis of little or no formal training (Simpson 1997). However, this is not to devalue the knowledge and skills that informal caregivers have acquired, and to imply that care based on formally acquired knowledge is in any way superior. Indeed the professional – informal split has been identified as a false dichotomy by authors such as Land (1991) and Waerness (1987).

1.9 Chapter conclusion.

The ambition of the NHS was to “solve” the problem of ill health through cost-effective means, to which all citizens would have access. In so doing the state would provide and maintain a healthy and reliable population, which, according to the Marxist critique, would protect profit (Doyal 1983). It is evident from the variety of changes and reforms in the NHS

that a number of imperatives bear responsibility for driving government policy, of which there are several competing accounts, the Marxist account being only one. It is also apparent that changes to the location of care have been strengthened by an idealised notion of “community”. But it remains that the movement towards community care, whether as the result of a quest for a cheaper or a more humane system of care, or as a necessary consequence of a capitalist society, or merely as a poorly thought out system, is firmly embedded within policy. Funding statistics demonstrate that while the institutional model of care traditionally had primacy over community services, the annual spend increases. Figures from the Scottish Executive estimate that the net expenditure for community care reached 803 billions in 2002-2003.

The NHS and Community Care (Scotland) Act 1995 and the *Carers (Recognition of Services) Act 1995* confirm that the community as a mode of care is now firmly entrenched. The growing demand for informal care coupled with its recent recognition in strategic proposals with the policy document *Caring About Carers: A national strategy for carers* (1999) and the *Community Care and Health (Scotland) Act 2002* in effect cement the position of informal caregivers in the health and social care paradigm. Government policies have an undisputed effect on the nature of choices available to the population. The fact that informal care has received the recognition it has fought for and clearly deserves, means that exercising a choice *not to be involved* in the care of a relative may be more difficult than when carers were unrecognised in legislation.

Chapter Two

Informal Caregivers

2.0 Chapter Introduction.

Care in or by the community is an increasingly complex subject and one that continues to develop over time. In response to this, academic debate and research has been far reaching in the quest to describe and expose issues which span from the production of social policy to the practical experience of care giving and its consequences on relationships, income and health. The following literature review provides a broad sweep of the major themes of empirical research and theoretical debate. For the purpose of organisation it is necessary to attempt to impose some order on the multifaceted and often overlapping issues. This chapter is defined therefore, reviews the “paradigm cases” or themes of debate on informal care. Some appraisal is made of empirical investigations of both qualitative and quantitative design. In addition, academic perspectives on informal caregiving are drawn together to provide a comprehensive review of the subject area.

2.1 The variables.

Much of the empirical research in informal care has been non-critical, but nevertheless provides a necessary attempt at establishing the contextual variables of the population of carers and the recipients of that care (Green 1988; Twigg 1992; Twigg & Atkin 1993; Bauld 2000). A large number of such studies have revealed the demographic characteristics of age, gender, education, household, income, relationship to patient, household composition and

employment status (for example Horowitz 1985, Green 1988; Parker and Lawton 1994) which are important variables in identifying the makeup of those involved in informal care.

Parker and Lawton (1994) in their analysis of data gathered from the General Household Survey of 1985 and the ESRC Data Archive examined the various dimensions of caring, for example, the age and the sex of carers, housing, marital status, income, caring activities and the services and support received. Their findings, which were later supported by Arber and Ginn (1995), indicate that women are chief providers of personal, physical and practical care. Male caregivers have less involvement in caregiving and are less likely to be the main caregiver. However, the analysis also revealed the hitherto unrecognised involvement of men in caring with as many as 10% from the sample of 2700 reporting some involvement in the care outside the household.

The General Household Survey of Informal Carers in 1985 estimated that there were 6 million carers in the UK. In that population 4:5 were caring for a relative, and 1:5 were caring for more than one person. Moreover 855,000 people were identified as spending at least fifty hours a week caring, however, this excluded time spent “on call” suggesting that the total number of hours may in fact be higher. The age of informal carers was also found to be significant in the likelihood of involvement in informal care with those over 56 often performing a greater number of personal tasks (Parker 1992). The Scottish Household Survey (2000) estimated that 12% of all Scottish Households have someone with care needs and that for 98% of these care is provided on an informal basis. While the General Household Survey of 1995 suggested that 1:6 people provide informal care, the Scottish Household Survey places the ratio at 1:9. The 2001 Census revealed that Scottish caregivers amount to 481,579 which represents 10% of the total number. In addition the Census indicates that in

Scotland the highest proportion of carers is in the 50-54 age group, representing 18.5% of that population. At the same time, residential care peaked at 46.8 per 1,000 population and has fallen since then to 44.2 in 2002. In addition, the number of people in long-stay geriatric beds fell by half between 1995 and 2002 to 4.0 per 1000 population.

As a balance to the numerous studies, which attempt to count the incidence of caring by the community, Alcock (1996) comments that the informal sector is so great that non-professional welfare activity cannot be counted. By definition, many of the activities are unrecognised as *activities* and will therefore not be recorded as such. They refuse to be “neatly pigeon holed” because they are part of the invisible social fabric from which society is built. Therefore interpretation of the variables hinges on how “caring” is defined by the sample. Would those involved in caring necessarily recognise it as such? Indeed can it be separated from what “normally” happens?

The increasing number of ill and dependent people being cared for at home by members of their family evidences the enthusiasm with which community care has been adopted (Walker 1982; Finch 1990). It is unlikely to change particularly in the light of predicted increase in the numbers of elders in the population will compound the imperative to provide some degree of domiciliary support (Hooyman 1990). As the carers of elderly people form the over all majority, roughly 75%, and with the number of elders increasing it is unlikely to change (Hooyman 1990; Parker 1998).

2.2 Gender critique of informal care

The community as a location for caring activity is now widely accepted as a morally preferable and generally a more appropriate site for dependent people. Thus caring for people in the domestic sphere has become a virtuous activity. The recent preoccupation with consumer-led services, patient empowerment and liberation have served as an influence in the widespread absorption of these principles.

Much of the numerical data mentioned in earlier sections, have in some way addressed the identity of informal carers in general. Understanding who carers are in particular is greatly enhanced by a stream of feminist research with its origins within the work of Oakley (1974) and Graham (1983) and their analysis of the domestic role of women. This has prompted an increasing emergence of critical debate as authors and researchers have moved to expose the inherent gender bias in community care policies and the way the policies generally disadvantage women (Finch & Groves 1980; Nissel & Bonnerjea 1982; Finch 1984; 1990; Ungerson 1987; Baldwin & Twigg 1991). The Equal Opportunities Commission was among the first to provide a comment on the inherent gender bias in community care and concluded

It remains the case that families are expected to provide care for the vast majority of the handicapped, the sick and the elderly, and, as is demonstrated in this study, it is the closest female relative to whom the task of caring usually falls. (EOC 1980 pg: 1)

The commentators such as those mentioned above, have provided a theoretical and empirical body of work to demonstrate that caring has been constructed as an activity that is considered to be primarily women's work because of their role in reproduction – the

essentialist argument being that it is their biological, and therefore “natural” function. An example of this is the perception that the “good nurse” is necessarily, the “good woman”. Caring work is predominantly seen as men’s work, therefore leaving caring, with its lower status, to women (Skidmore 1994). This perspective is supported by Greenhalg et al (1998) who examined formal service providers rankings of caring behaviours and found that male nurses value fewer caring behaviours than female nurses. Indeed earlier work by Evans (1997) and Kauppinen-Toropainen and Lammi (1993) supports this perspective. Indeed male caregivers according to Connell (1995) are frequently regarded as potential abusers and are for this reason are prevented in the US from working in obstetrics and gynaecology.

As women bear the greatest responsibilities for the welfare of families, policies for health and social care reflect this identity (Graham 1993, Hanmer and Stathman 1999). As Waerness comments, “It seems to be true that the probability of being institutionalised in old age is dependent upon whether or not you have a daughter” (Waerness 1987 pg: 114). Gibson and Allen (1993) suggest that as the majority of informal caregivers are female that existing provision for carers are phallogentric in that they support male privilege and exemplify the preferences of men.

Davis et al (1996) considered the experiences of service users who were terminally ill and found that spouses and daughter bear the brunt of caregiving. Indeed Qureshi and Walker (1988) have identified a “hierarchy of caring” in which women are uppermost on the list of people to be called on. Bauld et al (2000) also found in their sample of 237 carers that the largest group, 45% were daughters of the recipient of care, while wives make up 21%. 31% of the caregivers were found to be the sons of the recipients of care and 53% were spouses. This is an interesting reversal, which is indicative of the acceptability of care delivered by

daughters. In addition there was no evidence of male caregiver involvement with care delivered to in-laws. Indeed the authors comment, “male carers may only be comfortable or accepted providing [intimate care] to their closest relatives” (Bauld et al 2000 pg: 86).

The construction of “female qualities” essentially as carer and nurturer have been internalised by society and women themselves to the extent whereby they are judged (and judge themselves) by their capacity to care. While the social construction of women as “natural born carers” can have obvious disadvantages, it appears that for many, caring is fundamentally a worthwhile activity. For some women, a definitive characteristic of success is their ability to care for others and to make relationships work. This sense of identity provides a very valuable anchor point for women’s place in society (Graham 1983; Gilligan 1982). However, such factors have been hugely influential in sustaining a sexual division of labour, with women being over-represented in the aspects of both informal and formal care work. The substantial evidence cited in earlier sections acknowledges the disproportionate incidence of female informal caregiving.

Fierce critics of policy makers who have constructed community care as the “solution” to problems of contemporary health and social care (see for example: Finch & Groves 1980; 1984; Land & Rose 1985; Ungerson, 1987; Lewis & Meredith 1988), take issue on the point of the heavy burdens of care giving. Their argument being that the burdens which fall largely on unpaid women save service providers vast sums of money, equivalent to the total health and welfare expenditure on the over 75s (Finch & Groves 1980; Dale & Foster 1986; Finch 1986). Indeed Nuttall et al (1994) for the Institute of Actuaries estimated the value of informal care at 34 billion GBP.

The construction of the location of “the community” is perhaps at the root of this problem, in that it necessarily presupposes the existence of a network of helping relationships that extend through and beyond the family. It implies a range of traditional values that are perhaps outmoded, if they ever existed at all (Alcock 1996). Relationships both in, and external to families have undergone significant change. The extended family now no longer implies close knit family members, but merely distant relatives, who may or may not be inclined to rise to the occasion when a member is disabled or ill.

In the examination of some of the most influential literature we see as examples, Lewis and Meredith (1988) whose often-cited research has focused on the roles of daughters caring for mothers. Interview data resulting from the “caring biographies” of 41 female respondents who had been co-resident carers, demonstrated the diversity of experience in the caring relationship. While Parker (1993) has documented the experiences of dependent men or women in spousal relationships and the demands that this places on marriage.

Research by Nissel and Bonnerjea (1982) again substantiates women’s involvement in care given by the family. Data from their sample of 44 married couples, who cared for an elderly relative, suggested that the burden of care is borne unequally. While the wives’ were estimated to be spending an average of two to three hours a day caring, an estimate of the husbands’ activity pointed to an average of eight minutes. Oliver (1983), Holzhausen (2001) and Doherty et al (1998) support these findings and conclude that a male patient is more likely to be discharged from hospital early if he has a wife at home to look after him.

However, studies have revealed the hitherto unrecognised role of men in informal caring (Bowers 1999). As noted previously it has largely been thought in terms of a more or less

complete bias towards women (Allen 1985). However, data from the General Household Survey of 1985 indicated for the first time that a sizeable proportion of men were involved, but confined predominantly to spousal relationships, and fewer men than women carrying out the heavier aspects of personal care (Parker 1992). Research conducted by Capability Scotland (2000) estimated that 67% of informal caregivers in Scotland are female compared to 32% male. A recent review of community care conducted by Bauld et al (2000) estimated that 72% of principal informal caregivers are women. They report that male caregiving increases with the physical dependency of the recipient of care.

2.3 The activities of informal carers.

Others have focused on the analysis of the various caring activities. Again data collected from the General Household Survey providing a medium for investigation. Parker and Lawton (1990) have used data to develop a “typology” of caring activities based on the tasks defined by the survey. These ranged from personal care such as bathing and toileting and assistance with mobility, down to “popping in” to see that the cared for person was all right. This supports earlier research by Johnson (1987, pp: 90) who lists the categories of activities regularly provided by relatives as personal care, domestic care, auxiliary care, social support and surveillance. Only the latter two categories of social support and surveillance are likely to involve non-family, such as friends and neighbours.

Bauld et al (2000) found that medical care and toileting was performed by a 28% of informal caregivers, personal care such as washing and bathing was dependent upon whether the caregiver was co-resident. In this case 83% of informal caregivers perform these tasks, many of which have a technical element such as changing catheters and tube feeding. The

movement towards involvement of informal caregivers in quasi-medical care is not without its critics. For example, Symonda and Kelly (1998) regard it as a version of post-Fordist “skills mix”. Housework is performed by 75% of caregivers, while 84% are responsible for meal preparation. The findings also highlighted that where the recipient of care is less dependent, the caregiver is more likely to provide support with shopping. Furthermore the research identified that 97% of informal caregivers provide company and leisure opportunities for the recipient of care. Interestingly there is an inverse relationship between this activity and the degree of cognitive impairment of the service user. Finally Bauld et al (2000) found that 70% of caregivers provide help and support with administrative tasks such as securing benefits and maintaining finances. From the sample roughly one third reported that they experienced difficulties with the tasks, particularly in relation to the delivery of personal care and medical assistance.

The issue of personal care such as washing dressing and feeding, again feature as a gender issue for Ungerson (1987) who purports that they are considered essentially as women’s activities. Men are more successful at getting other people to accept that they couldn’t and shouldn’t “do that!” This apparent disproportion may stem in part from societal and cultural taboos that restrict men’s involvement with nakedness and excreta, often features of the personal care of vulnerable or dependent adults and children. Research Wright (1986) pointed out that male carers are more likely than their female counterparts, to receive support from statutory agencies, the reason being perhaps to do with the same cultural taboos.

The principles which determine who is the appropriate source for personal care have also been categorised by Qureshi and Simons (1987) who suggest that the marriage relationship is the primary port-of -call. Again categorisation on the basis of gender is a central feature with

the consideration that personal care is more appropriately delivered by women. So daughters, then daughters-in-law will be utilised before sons (Henwood & Wicks 1985).

2.4 The impact of caring.

Caring activities in the domestic sphere have until recently been private and thus largely invisible. But as the ideological interpretations on health and social policy have changed, so increasing visibility has been brought to the informal community. With the development of community care policy it has become expedient to estimate and evaluate both the emotional and material costs of caregiving. The main themes of research and debate have centred on the examination of the carer's experience, the documentation of their needs, the financial costs and implications on quality of life.

Glendinning (1992) and Qureshi (1990) have focussed on the often poor financial circumstances that long term informal carers often find themselves in, particularly the wives of disabled husbands (Parker 1993), and how they can be better supported via the benefits system or through direct financial re-numeration. On this point General Household Survey (1985) data (Arber & Ginn 1992) pointed to the inherent class inequalities in informal care. The analysis suggests that it is the "working class" which bears the greatest burden of informal care, but in paradox it is this section of society that has the least resources with which to manage this effectively. Moreover, they comment how the ability of informal carers to enter the labour market is affected and how this is compounded by the higher than average living expenses of caring for someone at home. This in a sense imposes restraints that work to cement their position in society and therefore maintain a class structure.

The General Household Survey has provided a rich medium for secondary data analysis. Arber and Ginn (1995a; 1995b) utilised the 1990 survey to examine the impact of informal caring on paid employment. Not surprisingly they suggest that individuals who care for co-resident kin are less likely to be employed outside the home. Moreover, the effects are greater for women than for men. However, the analysis reveals an increasing number of people trying to combine both activities. The 2001 Census found that over half of all caregivers do some form of paid work. This reflects Joshi's (1995) findings, which suggest that employment and caregiving are compatible as the main wage earner is often the caregiver. The Carers National Association (1996) suggests that 75% of caregivers experienced an average annual salary loss of five thousand pounds and that caring can reduce wages by an estimated 12%. Furthermore in 2000 the Carers National Association found that six out of 10 carers live in households without any paid employment and that one in three are in receipt of income support. Of these 70% have given up work to undertake caregiving. In addition older carers are more likely to have to spend their savings to fund caregiving, while 50% of Scottish carers have no savings and 33% cannot afford to pay their utility bills.

In the research undertaken by Bauld et al (2000) 58% of the informal carers reported that they had experienced ill health in the last twelve months. This increased if the recipient of care was cognitively impaired and this was a greater issue for those that were co-resident. The 2001 Census identifies caregiving as a factor in poor health with a significant correlation between the hours spent providing care and the degree of illness. For example 23,719 of those caring for 50 or more hours per week described themselves as "not in good health". 32,322 were said to be "permanently sick or disabled". Of these, 5,322 provide care 50 hours per week or more. This echoes the findings of Evandrou (1996) who identified a number of potential effects of caring on health. The direct effects concern the physical and emotional

strain associated with caregiving. The indirect effects centre on the lower income and overcrowded housing conditions. Both direct and indirect effects combine to impact on the health and well being of the caregiver. a longitudinal study conducted by Taylor et al (1995) found no evidence of deleterious effects of caregiving on health.

Waerness (1990) focuses on the changing social context of the family and the implications that this has for community care policy. The tension for her lies in the way that governments have promoted informal care without regard to the changing intergenerational bonds between kin. Divorce and remarriage deepening the complexity and blurring the boundaries on whom can legitimately make claims on informal resources.

Many researchers have investigated the stresses of caregiving and how best to support the growing population of informal carers (Zarit et al 1980; Raveis et al 1990; Chiriboga 1990; Neal et al 1997; Kelling 1993; Meredith 1997). The imperative for the concern seeming, in part to stem from the desire to ensure that informal caregiving continues without interruption. It is with this end in mind that coping strategies such as involvement in care support groups as a method of combating loneliness and isolation has often been recommended (see for example Bergman-Evans 1994). However, any positive impact that this might have is open to debate according to other authors (Smith & Cantley 1985; Twigg & Atkin 1994). Concern for carer welfare seems, in some ways to be superficial in the implication carer stress is an important indicator for professional intervention, particularly when willingness to continue care is at risk.

Futhermore the idea that the goal of the service provider should be in helping the carer to cope under extreme pressure by intervening with the occasional offer of a temporary respite

does not in any way represent a challenge to the status quo. Many carers have expressed fairly ambivalent views on respite care, citing concerns about the quality of care and supervision given. It seems that some are caught between the need for a break and feelings of guilt about not being able to cope in the way they perceive they should. (Twigg & Atkin 1994).

Research by Almberg, Grafstrom and Winblad (1997) on a sample of 52 family caregivers suggested that older wives and daughters were more likely to experience caregiver burnout. Limitations to social life and poor health were found to be significant determining factors. In empirical research by Orbell et al (1993a; 1993b; 1993c) and Orbell and Gillies (1993), an attempt is made to measure the impact of the family care of elderly people and its association with strain, dissatisfaction, and the wish to cease caring. The emerging picture is that characteristics such as the levels of social support which informal carers had, the way that they perceived their own caring competence, coupled with possible behavioural problems of the cared for, particularly dementia, were significant factors in the overall levels of satisfaction, or expressed dissatisfaction.

Jones and Peters (1992) suggest that policies should reflect the specific needs of caregivers. From a sample of 256 informal caregivers, daughters reported the greatest levels of stress, anxiety and loneliness. England (2000) in a collection of secondary data suggested that nurses need efficient and effective ways of recognising signs of caregiver strain and that diagnostic cues such as exhaustion and emotional arousal can be indicators of caregiver role termination.

The care of people with dementia has long been highlighted as a particularly burdensome activity for its association with difficult behaviours such as confusion, wandering and

forgetfulness resulting from global cognitive impairment. With the increasing clinical endorsement of the community as the location of choice for the care of people with dementia, it is easy to see the possibility for depression and demoralisation amongst informal caregivers. Indeed Bibbings (2000) found that such situations can lead to abuse. Thus there has been increasing impetus towards the development of a typology of circumstances, which could predict unsuccessful outcomes in informal care (Lewis & Meredith 1988; Orbell et al 1993). This has been supported by Ballard et al (1995) who utilised several rating scales to measure psychiatric morbidity in a sample of 109 caregivers involved with caring for people with dementia. Bauld et al (2000) utilised The Rutter Malaise Inventory (Rutter et al 1970) and the Kosberg Cost of Care Index (Kosberg and Cairl 1986) to illustrate the impact that caregiving has on the mental health of informal caregivers, particularly when the recipient of care has a degree of cognitive impairment.

Several studies have been conducted with research being targeted at the measurement of caregiver strain and service provision in a given diagnosis. Montgomery et al (1990) in their survey of caregiving difficulties with Alzheimer's disease suggested that the cause of the impairment is unreliable as a method of predicting caregiver strain. This is contradicted in earlier research by Zarit & Zarit (1986) who conclude that a diagnosis of a condition associated with disruptive and irritating behaviours can be correlated to a greater degree of caregiver difficulty. Almberg et al (1998) looked for a difference in the levels of caregiver strain within and between the genders. From a sample of 52 caregivers of demented elderly people males tend to lack a positive outlook and require greater levels of social support. Other authors differentiate between caregiver burden and caregiver strain (Vitaliano et al 1991; England 2000; England and Roberts 1996) and comment that the two constructs are frequently confused. This confusion creates difficulties in terms of diagnosis. However, it is

clear that in defining the two as distinct “conditions”, external and medically orientated criteria are being applied to entirely subjective experiences. Aarsland et al (1999) investigated the social and emotional effects that caring for a service user with Parkinson’s disease has on informal caregivers. Their findings equated a greater level of Parkinsonian symptoms with greater levels of caregiver distress.

Much of the available empirical studies fall into similar themes, but often with conflicting conclusions. For example Jorm et al (1993) concludes that caring for physically disabled relatives is associated with higher levels of carer stress. While behavioural difficulties, are cited as producing fewer caregiving problems. De Meneses and Burgess Perry (1993) have looked at some of the situations, which cause higher levels of stress and make the suggestion that service provision such as respite care and meals on wheels are suitable methods of preventing “burnout” (1993 pg: 13). In the statistical study conducted by Miller and McFall (1991), factors associated with a reduction in the perceived stressors included the availability of informal support networks in which a greater number of relatives contributed to caregiving tasks. Sales (2003) question the usefulness of constructing caregiving as burdensome. In drawing attention to “burden” as an aversive label Sales is mindful of the implication that the recipient of care is unwanted when indeed many caregivers view caring as an obligation and one that is willingly incurred. Many studies have sought to identify the impact that personality characteristics have on the levels of burden experienced (Hooker et al 1992; Monahan and Hooker 1995). Hollis-Sawyer (2003) from a sample of 112 mother and daughter pairs found that emotional closeness and sensitivity to each others needs, together with an understanding of “self” can mitigate against caregiver burden.

Little is understood about why some caregivers fare better than others (Farran et al 1999).

The apparent confusion around what constitutes a stressful situation is evident from the literature. It is clear therefore, that attempts to predict or gauge stress to a generalisable level is fraught with difficulties considering the complexity of human experience and the differing coping abilities among the caregiving population. there is overwhelming evidence that providing care to sick and disabled relatives is the cause of considerable emotional and physical strain resulting in a significant reduction in quality of life (Jones & Peters 1992; Atkinson 1992). Evidence for the Dundee Study of Institutionalisation (McKee et al 1999) examined the impact that dementia has on informal caregivers found that institutionalisation was more likely to occur when the caregivers of individuals with dementia were not their spouses. In addition the study highlighted the need for carers to have their own needs assessed.

Although such findings seem entirely reasonable, this research can be contrasted with data collected by Stone et al (1987) which comments that the beneficial effects of caring are often underplayed. Caregiving, according to three-quarters of their research sample affects familial relationships positively, providing company often for both carer and recipient, while making the caregiver feel useful. Some of the mother-daughter relationships in the study conducted by Lewis and Meredith (1988) were said to blossom, both categories of individuals deriving considerable security from the activity. Rhoades and McFarland (2000) support this with the suggestion that caregiving can enhance quality of life by providing a sense of self-fulfilment through feelings of purposefulness and meaning. Research conducted by Yamamoto-Mitani et al (2004), from a sample of 381 concluded that feelings of confidence and mastery can be experienced in caregiving. Butcher and Coen Buckwater (2002) considered the stress associated with caregiving and investigated the effect that narrative accounts can have on

how informal carer. The authors suggest that reading the narratives of others and writing about one's own experiences can enhance coping ability when caring for a relative with Alzheimer's disease.

There has also been considerable interest in the impact of carer support groups. As a venue to meet people who are in similar circumstances, a number of authors have suggested that carer support groups are one of the few facilities, which exist to provide direct support for informal carers. Carers in general, by nature of their role can experience significant social isolation but meeting with others who share a common identity can provide a forum to vent feelings and exchange information particularly in the area of benefits and services (Glosser & Wexler 1985; Toseland et al 1992). However, research by Twigg & Atkin (1994) has highlighted a mixed response to support groups from carers, some agreeing on the positive value of support groups but others commenting that they were of limited benefit. Factors such as, professional involvement was perceived as being detrimental to the dynamics of the meetings, with many service providers seeking to orientate groups towards a psychotherapeutic model, often disapproving of "social chit-chat" and fundamentally sabotaging the natural inclination for members to form friendships with others in the group (Twigg & Atkin 1994, pp: 94).

In an empirical study by Healy and Yarrow's (1997) those caring for elderly relatives were investigated to determine the types and levels of support required. Their sample comprised mostly daughters caring for mothers and pointed to carer's needs as centring on the need for information, choice, a regular income, support in the workplace, adequate, responsive and affordable service provision and suitable housing provision that can adequately accommodate the service user. Healy and Yarrow (1997) argue that the burden of care would be reduced if these needs were met.

New technologies for communication such as *NHS 24* have offered alternative forms of support for caregivers. Colantonio et al (2001) for example, evaluated the use of telephone help lines, email and newsletters as a means of support in caring for people with dementia. From a sample of 148 informal caregivers many expressed an interest in such services, but few were found to have used them. This suggests that further research needs to be conducted to establish helpful support strategies.

2.5 Factors motivating informal carers.

In the light of research described in the previous sections it is apparent that caring for dependent kin carries with it the potential for enormous impact on the lives of both recipient and carer. Why then do relatives make a conscious decision to care? The answer according to Lewis and Meredith (1988) is that they don't. In their research study of daughters who cared for mothers, few reported that the decision was at all conscious but was more of a gradual response to the needs of the dependent person. Many were already living with their mothers, which more or less prohibited a refusal. Bauld et al (2000) in their overview of community care in the 1990s found that the single largest group of carers care for their parents or in-laws.

What are the motivations besides household membership? A number of authors have looked to other circumstances, which work to create a "caring ethic" (Lewis & Meredith 1988; Ungerson 1987; Qureshi & Simons 1987; Henwood & Wicks 1985). The sense of "repaying a debt" has featured heavily, implying a sense of duty and responsibility to the recipient of care. Others have been motivated by feelings of love, particularly when the initial relationship

was of a high quality. Schulz (1990) however, has identified specific motives such as egoism, empathy, altruism and reciprocity as the bases for care giving behaviour, or perhaps as Finch (1990) suggests, as a response to the possibility of immanent financial inheritance, although this is never overtly referenced among families.

Studies have tended to focus on the negative aspects of informal care and authors such as Nolan et al (1996) point out that such research rarely considers the satisfaction and rewards. Other studies have found that caregiving can enrich a relationship and that satisfaction can be gained from seeing the recipient of care happy and comfortable (Cartwright et al 1994; Kane and Penrod 1995). In the study conducted by Bauld et al (2000) 81% of the sample cited love as the major factor in the provision of informal care, while 38% reported duty as a reason to provide support. 22% felt that there were social expectations from others and that this had been a factor in involvement. Financial reward was identified by only 2%. Clearly spouses are more likely to cite love as a motivation and while female caregivers such as daughters identify the motivation as duty.

For the research conducted by Twigg and Atkin (1994) some caregivers have revealed that they did not fully appreciate the extent of the responsibility and confessed to having a general lack of understanding of the extent to which the caring relationship would restrict them. However, there is also the suggestion that the burdens of caregiving are to some extent influenced by the dynamics of the relationship. If the relationship had been strained prior to the need for direct care, then this is often cited as a factor in the wish to discontinue caring (Orbell 1993).

Finch (1990) also provides a perspective on motivation by looking to the spectrum of rewards or benefits, not just in material terms but in the sense of personal gratification and the fulfilment of the feminine role. A theme appraised in previous sections. She reminds us that feelings of obligation “do not develop in a vacuum” but are formed as a response to the ideology of the time (pg: 7). Therefore obligation and duty are manipulated by the state to fix boundaries around responsibilities. The imposition of a moral order on society ensures that family intervention reduces the claims on collective resources. These boundaries are in a constant state of flux, as the ideological construction of the role of the state shifts.

The consequences are that the family has been ascribed as the ideal location for caregiving, support and protection by society under the influence of the state. It is accepted to the extent whereby it is perceived as natural (Finch & Mason 1993). As the family is defined by those characteristics it will feel obligated to enact the responsibilities, as failure to do so will produce guilt. So we have a circular model in which normative guidelines on role, work to define obligation until such a time that it is considered expedient to change the ideological boundaries (Crowther 1982). The social construction of kinship obligation is an important concept. in the final analysis, it is self-evident that the family *is* the location for spontaneous feelings of love and affection despite being subject to the manipulation of the state.

2.6 Service provider response to informal carers.

The concept of an informal carer lacks a clear definition (Twigg et al 1990) for a number of reasons, but primarily because caring work constitutes a number of social and reciprocal activities, which cannot be separated for the process of analysis. This lack of clarity of definition reflects the ambiguity of informal carer in the service system.

According to Ungerson (1990) the title “informal carer” has been developed by the service system in an attempt differentiate between trained professional care and care that occurs in the familial setting by untrained and unregulated family members. Moreover it evidences the way that aspects of care have become “professionalised” and subject to, scientific as well as economic rationality. Waerness (1987) in particular cites nursing as an example of where the development of formally acquired knowledge has necessarily devalued the informally acquired and intuitive kind of knowledge and skills gained through practising informal care within the domestic sphere.

Although the term is now almost globally ascribed to carers, Twigg et al (1990) comment that carers do not recognise themselves as such. For most, caring for dependent and vulnerable close family members is merely a feature of the normal familial relationships, which exist between kin. To be ascribed a “quasi-employment” label to describe an essential element of a close relationship is alien to many (Twigg et al 1990 pg: 3). This reveals much about the way that informal carers are regarded, by their formal counterparts.

The community nursing service has been identified as important contributor to the support of informal carers. Bearing responsibility for needs assessment for health and sometimes, social care provision the community nurse liaises with a number of other agencies and holds a powerful position as client and carer advocate. The professional training for community nursing endorses this position with the philosophy of “holistic” assessment of not only the client but also of their social setting and social resources. This broadened domain differs from that of the hospital setting and its often narrow, client-only focus, in philosophy if not in reality. As there must necessarily be an integration between formal and lay care in the

community setting, commentators have pinpointed the potential in community nursing for the support of informal carers (Atkinson 1992; Atkinson & McHaffie 1992). This is acknowledged by Baly, albeit with echoes of paternalism:

The most important caregivers are usually the patient and his family and so it is important for the nurse to assess their ability to cope with the care involved and ensure that they have been taught how to carry out this care. (Baly 1984 pg:121)

The study conducted by Twigg and Atkin (1994) suggested that the practical reality is somewhat different with most of the practitioners perceiving their role within the confines of a medical service with little overt orientation to informal carers. In fact carers could receive support from service providers at the point at which medical/technical activities were taking place. Research by Twigg and Atkin (1994), with a sample of 90 informal carers and 125 service providers revealed the extent to which this regard reflects the way agencies see their obligation to support the carer and/or the cared for. Empirical investigations such as this, which use a qualitative method, are valuable for what they reveal about the “assumptive worlds” of professional carers in the determination and identification of need. It is striking to note that the decisions on the nature and extent of support to be offered, is often based on the way professionals construct the meanings of family and kinship (see for example Heron 1998).

Household structure is shown to be an important basis for intervention, for example if the dependent person lives alone or co-habits with family. Furthermore, the social class of the family caring for the vulnerable person also features heavily in the way that professional carers perceive need. Although such perceptions are rarely stated explicitly, it is apparent that

the inferences are some how influential in the decision to support carers. These findings are supported in a comparative study conducted by Davey and Patsios (1999) who found that in the UK and the US, services are targeted to elderly people who are living alone and those without a spouse or relative living nearby.

This research can be interpreted as suggesting that professionals hold strong views on familial obligation. This point has been taken up by Finch (1990), who confirms that, *taken for granted* genealogical principles produce expectations regarding who can be expected to contribute to care. This takes on more significance when it is the service providers at “street level” who exercise enormous discretion in how to respond to carer and client-need (Lipsky 1980). Although public service workers such as home carers, district nurses and social workers are responsible for carrying out policy directives and have to work within tight budgetary constraints, they retain the power to respond in a variety of ways. Indeed Baldwin and Woods (1994) and Watters (1996) highlight that service provider responses can be quite idiosyncratic and often do not acknowledge the informal caregiver’s expertise. Conversely Henwood et al (1996) suggest that formal service provision is keeping pace with caregivers needs and responding appropriately.

This particular point has been noted by Levin et al (1989), who demonstrated an apparently, inverse relationship between individuals in the greatest need and service response. Their research evidenced a tendency towards greater service input in situations where the client lived alone, the concern being that the client was “unsupported”. As a consequence, service provision was biased against clients who were co-resident even if in situations known to be particularly burdensome, such as caring for someone with dementia. Therefore, the

individuals who perhaps needed a greater level of support actually were in receipt of less.

Thus success is penalised and failure is rewarded.

Moreover, there is a tendency for service providers to make assumptions on the basis of age.

Twigg and Atkin's study (1993) revealed that service practitioners interviewed could justify a greater level of input to support younger caregivers on the basis that they were entitled to have a social life. For older caregivers it was seen as a less legitimate use of resources, the assumption being that socialising is less important to older carers.

To summarise, service providers are responsible for the professional definition of need and are aware that consumer interest should be reflected in this process. However, the influence that informal carers can exert is obscured by practitioner assumptions concerning the role and availability of informal carers. At the same time service providers and planners reflect strong views regarding kinship obligation and with this comes the assumption that to care for one's own is, "the proper thing to do" (Finch 1990, pg: 142). Twigg and Atkin, from their research suggest four possible models of professional regard for carers in the service system.

The first model pivots on ideas concerning family responsibility, as referred to earlier, the service provider believes in the primacy of familial obligation. This model constructs the informal caregiver as a form of resource that can justifiably be exploited. As a parallel, formal service provision exists primarily as a "safety net" when no informal actors are available.

The second model has similarities with the first in its recognition of the carer as a resource, however, the informal carer is constructed in this instance as a co-worker. As they have the same aims as professional carers - the care of a dependent patient, informal carers can

legitimately be co-opted into the provision of care. Caring is therefore a “joint enterprise”, with the difference being that carers interests and needs are recognised to some extent. this comes with the understanding that service providers can and will withdraw when they perceive the carer to be “managing”. Carers then have to present a case to have formal service provision reinstated at a later date if they are unable to cope without formal input.

The third construction is the carer as co-client. Again building on the previous model the carer is perceived as an important actor but is not exploited in the same way. Indeed attempts are made to limit the burden of care and reduce strain, even to the extent of upholding the needs of the carer above those of the client. Hence the client may be referred for temporary institutional care to allow the carer a short respite.

In the fourth and final model the carer is viewed fundamentally as a *relative*, one whose existence is not merely to provide care work for the client. This construction sees the client and carer as quite separate beings with the emphasis on helping the client towards independence. For obvious reasons this model features more in the area of physical and learning disability when the goal is to maximise independent living and reduce the clients over all dependency.

This brings us to the debate regarding the way that constructions such as those featured above offer an insight into the world of community nursing. It is clear that the community nurses in Twigg and Atkin’s sample, “positioned” informal carers within the context of their understanding of how society is structured. They not only *describe* the way that community nurses see caregivers, but actually function to *produce* those particular constructions.

Twigg and Atkin (1994) conclude with the observation that service providers do not draw exclusively on one model or the other, but that each situation produces a differing response. Therefore service providers do not, as has been suggested, respond with a set of recommendations for service input based on purely rational principles. Need is defined in accordance with the “assumptive worlds” of practitioners, which itself is influenced by a variety of ideologies.

As alluded to earlier, service provider response is influenced by a number of other variables. A review of research by Atkin (1992) considers social class as a key determinant of service provision. It has been documented elsewhere that the middle classes enjoy better health and health service access than families who are less well off. Moreover, middle class families can negotiate their way around the system in ways that the working classes find difficult (Townsend 1981; Wenger 1984; Parker 1990; Robinson & Stalker 1992).

Evidence from a number of commentators (Finch 1990; Arber Ginn 1991; Twigg et al 1994) demonstrates that service providers carry with them ideas, which suggest that lower income families need to be encouraged to fulfil their obligation to care for kin. Hence, these groups know less about the availability of respite services, often receive less help with personal care, and are more likely to be caring for kin than their higher earning counterparts.

As a contrast a number of authors report an increased responsiveness to informal caregivers (Henwood 1995; Lamb and Layzell 1995). While Warner’s (1994) findings follow a similar line of thought, the conclusion is that service providers could do better. This seems particularly the case for ethnic minority groups who often experience discrimination as a result of stereotypes and as a result have inappropriate provision (Katbamna et al 1997).

Interestingly Rowlands and Parker (1998) found a correlation between increased caregiver involvement and reduced GP visits as well as a reduction in community nursing input where the caregiver and recipient of care are co-resident. Indeed Twigg and Atkin (1994) found that the majority of GP's do not see themselves as a source of support for caregivers.

Furthermore, Town et al (1997) point out that however, well community care is resourced, the most important factor and indeed the most variable is the knowledge and skills of formal service providers. This means that community care can work well but it is contingent upon adequate staff training. Research conducted by Walker et al (1999) and Goulourne et al (2000) found in a study involving 20 caregivers and 18 formal multidisciplinary service providers, that the involvement of informal carers in planning and decision making was dependent to a large degree upon their assertiveness but that involvement was crucial to caregiver satisfaction. The GP was again highlighted as an important contact in community care. Indeed Barnes and Walker (2000) assert that despite recent legislation, service providers are slow to encourage caregiver participation in decisions that affect them.

Gender in caregiving is an important factor, however, studies have largely neglect an exploration of the part played by service providers in creating and sustaining the status quo. While Twigg and Atkin (1994) referred to the "assumptive worlds" of practitioners and the influence that this has on the levels and types of services offered, Bates and Thompson (2002) comment that male caregivers frequently receive more support from formal service providers by virtue of the maleness. The assumption being that additional support is required because men do not have the skills required. On this note research undertaken by Lund and Caserta (2001) suggested that while men were more likely to be offered more services, they were less likely to accept it because of their pride.

2.7 Conclusion.

The abundance of inter-disciplinary research and extensive literature in the area of informal care evidences its richness as a topic. While it is difficult to draw boundaries around the various categories in the network of service provision, the literature reviewed has necessarily been eschewed towards the health service and social work sectors. In this chapter discussion began with the demographic profile of informal caregivers and findings, which demonstrate that there are a significant number of people meeting the needs of sick and dependent relatives on an informal basis. Analysis of the activities of informal carers and the implications of these for quality of life has also been explored to reveal the differing experiences.

A key strand to the review has been the body of empirical work regarding the role of women in the provision of informal care and how service providers, as the controllers of resources encourage the familial model of care which binds women to the role of caregiver. Evaluation of the literature suggests at first glance that service provision is allocated in a fairly arbitrary fashion. However, on closer inspection it seems that service practitioner's decision making is guided by a "common-sense" view of the world. This common sense is founded on a number of ideologies that colour and shape their interpretation of the social world. Although popular professional rhetoric maintains that the health and social service sectors has a tested knowledge base and is a forum in which rational and reasonable decision making takes place, this overview of pertinent literature demonstrates to some extent, to the contrary. It is clear that further analysis should therefore focus on the possible influencing factors, which may give an insight into how or why women take the lead in terms of informal care.

Chapter Three

Methodology

3.0 Introduction

The previous chapter reviewed the literature on informal care and set down the intention to examine the theme of gender within this environment. The following chapter provides a brief overview of quantitative and qualitative methodology. The disciplines of ethnomethodology, conversation analysis and discourse analysis are summarised to reveal their distinctive characteristics as methodological approaches. Discussion then moves to a justification for the use of discursive psychology with reference to the aims and objectives of this particular thesis.

3.1 The Scope of Research Methodology

Methods of conducting research tend to fall into qualitative and quantitative methodologies and the choice of research method depends upon the type of knowledge researchers intend to find out. Both methodologies have been extensively critiqued elsewhere (see for example Silverman 1993; 2000 Bryman 1988) but it is important to examine their epistemological vantage points in order to distinguish their features. Quantitative methods are often referred to as the “scientific method” of fact gathering through social surveys as an example. Social surveys fall into two main types, the *descriptive* and the *analytical*. Descriptive social surveys are designed in the main to describe the attitudinal or behavioural attributes of particular groups or individuals and from this to generalise from that sample to others in the wider

population. This inductive tradition has been built on the premise that the maximisation of facts about the social and natural world will in due course allow scientific laws to emerge from the sheer weight of data collected (Harre 1972). Analytic or deductive social surveys have emerged as a means of verifying or disproving data collected through the testing of hypotheses. This approach or set of techniques became known as *positivism*.

The natural sciences such as biology and physics have had an enormous impact on our knowledge and understanding of the world. The individual scientist claims objectivity from the subject under study while collecting knowledge “scientifically” through the application of rigorous tests. However, their findings are expressed in a vocabulary that is specific to their tradition. Ways of seeing and knowing, according to Gergen (1999) are byproducts not of individual minds, but of community traditions that are, in this case lodged in the culture and history of science. This releases the possibility that the interests of science and for that matter, other disciplines bias the descriptions of the world. At this point, objectivity becomes suspect as the interests and values have unavoidably infected attempts to describe the world with neutrality.

Criticisms of the hegemony of the statistical method has a long history. Silverman cites commentary by C. Wright Mills (1953) and Blumer (1968), raising the point that mathematically driven studies do not attend to the social construction of meaning or how the individuals being studied define the variables. For this reason many researchers using statistical methods are forced to leave out aspects that do not fit within the predetermined parameters of interest. The accusation of reductionism exemplifies the criticisms. This is not to suggest that methods, which use hypothetico-deductive reasoning are of limited value.

Instead its use is more generally in the area of incrementally testing hypotheses and theory (Silverman 1997).

On the other hand, the interpretivist perspective in social science is commonly regarded as the opposite of positivism and thus we see the classic dichotomy between quantitative and qualitative research. According to Silverman (2001) interpretivism is concerned with the observation and description of the social world in which people think and have ideas and beliefs, which guide their actions. While “scientific” approaches maintain a detachment from the research in the attempt to make the methods theory and value free, the interpretivist sees the research as a joint venture, an act on the part of both researcher and informant, and indeed partial and situated (Taylor 2001).

Interpretivism is orientated towards qualitative research methods of which there is no standard approach. Marshall and Rossman (1989), for example suggest that there are in fact several research traditions that differ according to their relative degree of intrusiveness in data collection. Hammersley (1992, taken from Silverman 2000) has characterised versions of qualitative research as:

- A preference for qualitative data – the use of words rather than numbers
- A preference for naturally-occurring data – observation rather than experiment
- A preference for meaning rather than behaviour
- A rejection of natural science as a model
- A preference for inductive, hypothesis-generating rather than hypothesis-testing.

The task of reducing qualitative research to a list of criteria is fraught with difficulties as Silverman suggests in that it runs the risk of both over-generalising and distorting the similarities with quantitative research with the creation of artificial polarities. As an alternative Silverman proposes what he titles as *a prescriptive* model of qualitative or field research thus:

- Is theoretically driven rather than determined by technical considerations
- Encourages the examination of social phenomena as procedural affairs
- Should attempt to make the definition of variables problematic
- Field researchers should not turn first to non-naturally occurring data.

3.2 Approaches to Data Collection in Qualitative Research

Similarly Silverman (1993) suggests that there are four main methods of used by qualitative researchers. The first and one, which has been used extensively in cultural and anthropological studies, is observation in which the researcher attempts to observe socially located phenomena in context (see for instance Basso 1972; Becker 1953). Put simply, the point of observational research is to see things as they “really are”, by providing some perspective. The strength of this approach is that the researcher is able to describe and contextualise events to facilitate a greater understanding of what is going on.

A second method of qualitative research, according to Silverman is textual analysis, which necessarily involves the scrutiny of the written word. This offers diverse possibilities and can according to Watson, (1997 pg. 81) provide “a window on the world” for what it gives away about social phenomena. A variety of texts can serve as resources in the investigation of

everyday life. For example newspapers and billboard advertisements can provide a conduit into something beyond the actual words or images used. Files, historical records and statistical documents can also be rich sources for in-sight into the social or political contexts.

An extremely popular method for qualitative researcher is the collection and analysis of data generated from interviews. Interviewing is widely applied across disciplines such as medicine, politics and social science. Indeed Briggs (1986) suggested that 90% of all social science investigations utilised interviews for data collection for both qualitative and quantitative studies. But as Holstein and Gubrium (1997) point out, interviewing is more than just asking the right questions. They suggest that it is more akin to “prospecting” in that it takes a skilled interviewer who can remain neutral but ask pertinent questions that will extract as much information as possible on the experiences, feelings or beliefs of the interviewee.

It is this latter point in particular that is the subject of concern for many. How is the information to be viewed? Can it be considered reliable, valid and unaffected by bias on the part of the researcher? These issues are central to the debate regarding whether a response can be taken as true or false, and brings us back to the initial dialogue on the epistemological division between positivism and interpretivism. According to Silverman the positivist’s logic would have it that the interviewee is a passive vessel ready to divulge factual realities on request. With a carefully constructed sample and structured standardised questions, respondents who give “inaccurate” or contradictory answers can be removed from the study. For the interpretivist, the focus of the interview is the social context and the interaction between the researcher and respondent. They are in effect social events to which both parties contribute by inter-subjectively constructing meaning. Therefore the responses to questions

posed by the interviewer cannot be judged as true or false but as a reflection of, as Holstein and Gubrium (1997 pg. 117) suggest:

how and what the active respondent, in collaboration with an equally active interviewer, produces and conveys about the active respondent's experience under the interpretive circumstances at hand.

Therefore respondents' answers should not be treated as if they are rational and factual statements but nevertheless as *accounts*. In addition, Potter and Wetherell's (1987) focus on the inherent complexity of talk reveals the variation in respondents' accounts and indeed the way that respondents formulate accounts, which are dependent upon the situation, a topic that will be covered in greater detail at a later stage.

As the common thread binding the previously detailed sources of obtaining data for qualitative research is language, transcripts provide the medium by which language can be analysed. The transcript is essentially the written reproduction of talk and as such can be handled in a variety of ways to enable detailed examination and analysis. Transcribed data can be broken down into themes, coded and categorised to permit meanings to be drawn from it, dependent of course upon the focus of the investigation.

The end goals in research methods that pivot on language span a considerable range. The following section provides an overview of some of the contemporary methods used to examine language as an instrument of communication.

3.3 Traditions in Language

There is an increasing academic commitment to the study of discourse, which has stemmed in part according to Jaworski and Coupland (1999), from an intellectual insecurity in the traditional ways of explaining phenomena and how knowledge is constituted. The term “discourse” itself is subject to a number of definitions. Gilbert and Mulkay (1984) for example define it as “all forms of talk and writing”. On the other hand Foucault (1972) locates the meaning within the historical formation of knowledge through language (Hall 1997). Potter and Wetherell (1987 pg: 7) however, take discourse to mean “all forms of spoken interaction, formal and informal, and written texts of all kinds”.

The academic gaze has to some extent begun to centre on the part that language plays in the classification and structuring of all aspects of social living. It is in the building of knowledge that we are able to interpret and classify our experiences, thus knowledge is shared because of a shared conceptualisation that is made possible through language. Therefore language is the key component in the constitution of knowledge. We consider the social world to rest on “natural facts” which are taken for granted as a mere reflection of “the way things are”.

However, according to Berger and Luckman (1966) the world is made of up human constructs or conventions that give the appearance of something separate and external and with a life of their own. What is lost sight of is that individuals or institutions have given names to objects, to categories or to ways of being and such objects have become established to the extent whereby they have taken on an external independence. Such conventions or traditions are seen as natural phenomena and are accepted as part of the natural order of things. This is reinforced through the process of primary and secondary socialisation and becomes fixed as both a subjective and objective reality.

Simpson (1997) talks about the theory of gender and how the differences between boys and girls have become fixed and are regarded as “social facts”. For her “masculine” and “feminine” identities are subject positions that are created not as a result of biological or natural differences but as a consequence of positioning through discourse. So masculinity and femininity are not essences but are ways of living and thus biological differences become a signal for, rather than a cause of differentiation in social roles. Clearly language is the medium by which this occurs. Therefore, what we believe to be reality is in fact shaped and sustained by language or more precisely, discursive practices.

For further evidence we can look to Kenneth Gergen’s example of the condition known as “depression”, a category which was unheard of until the 1930’s but which has now become an accepted dysfunction and one that is referred to as if it is a social object independent of the thoughts and actions of its originators.

As mental health professionals declare the truth of a discourse of dysfunction and as this truth is disseminated through education, public policy, and the media, so do we come to understand ourselves in these terms. “I’m just a little depressed”. (Gergen 1999 pg. 40)

A significant body of work has originated from Foucault (1972) who has claimed that power relations drive linguistic practices, or discourses. Power, being the ultimate principle of social reality has created through the process of modernisation, apparatus for the support of specific types of knowledge or ways of knowing. For Foucault there is a direct relationship between what we “know” and why or how such knowledge is constituted through power relations.

Termed “disciplinary regimes” disciplines such as medicine, psychiatry, education and the like have the power to classify individuals or populations as healthy or unhealthy, normal or abnormal, intelligent or unintelligent. Again the example of depression given above demonstrates how psychiatry (a disciplinary regime) has generated a language of description (depression). A description that we carry about and in so doing participate in power relations. While Foucault’s work provides a useful macro perspective on discourse, its weakness lies in its anecdotal style, which does not allow scrutiny at the micro level.

Stainton Rogers and Stainton Rogers (2001) discuss sexuality and gender as a means of uncovering the mainstream ideas in psychology and the approaches to research and practice. They challenge the various paradigms in psychology such as biological, social and personality theories of gender. Taking a critical perspective they argue that traditional approaches produce particular forms of knowledge but that questions need to be asked about “*whose* knowledge it is – *who* made it?” (Stainton-Rogers and Stainton Rogers (2001 pg: 166). From the social constructionist perspective, knowledge is socially constructed and can be deployed for particular purposes. As there can never be “true” knowledge, it is clear therefore that the form that knowledge takes has implications for individuals and groups. They point out that knowledge is “discoursed into being” in that it is created through human meaning-making.

The study of language has a tradition of micro level analyses, which finds its origin in *linguistics* and has tended to concern pronunciation and the use of grammar. More recent developments have seen its broadening into the key areas of sociology and social psychology and in particular to the study of the production of meaning through interaction. The following section provides a synopsis of the different disciplines concerned with the language and texts.

3.4 Ethnomethodology

Ethnomethodology has developed from Schutzian phenomenology in that it addresses the “natural attitude of everyday life” (Schutz 1964). The researcher seeks to see things in context and understand how the individual makes sense of and create order in their social world. Ethnographic methods found their tradition in the study of non-western societies. However, contemporary analysis has broadened to include micro-cultures or subcultures in a number of communities of people sharing the same rules and the same understanding of the world (Baszanger & Dodier 1997). Ethnomethodology holds that the social world and the social order is constructed out of the interaction of individuals and for this reason its application has been extended to encompass the study of conversational interaction (Taylor & Cameron 1987). While at first glance it seems clear that language is used primarily to impart straightforward information usually of either a descriptive or factual nature, it can also be used to achieve certain ends.

This tradition of finds its routes in the ground-breaking work of J.L. Austin (1962) who drew attention to language as a form of action. Referred to as *speech act theory* Austin demonstrates how communication has a transformative power in that it has the ability to produce a certain action given the right context or conditions. Thus the concern should not just be with the utterances themselves or what is said but the issuing of an utterance in a speech situation. Put plainly, what is the intention of the utterance? Austin is introducing us to the concept that language can be made to perform work by cueing the listener/reader to interpret or understand what is being said in a particular way. This approach moves away from the idea of language as a mere instrument of communication and considers the social context of doing talk.

Of particular importance is the work of Harold Garfinkel (1967) whom explores how common sense knowledge shared by participants in interaction, creates and sustains the social world. It follows therefore that the members of a society learn the rules of interaction and how to follow them (Cicourel 1999). Garfinkel uses the term *indexicality* of meaning to describe how language and expressions alter depending on the context of use; the exact meaning only being evaluated in accordance with the context of the utterances. Therefore social interaction is a process in which the actors are constantly reappraising what is going on and changing their own behaviour using contextual factors to guide them (Potter & Wetherell 1987). For Cicourel (1999) an individual cannot be taught the rules of interaction without first understanding the social structure. What is emphasised is that behaviour during interaction is not governed in the deterministic sense by rules that have been internalised through the process of socialisation or through “hard-wiring” in the Chomskyan sense. Rather ethnomethodology takes the view that social actors have to constantly “work” at their interaction but with the rules in mind.

3.5 Conversation Analysis

Ethnomethodology is taken further in the discipline of conversation analysis or CA, which according to Hutchby and Wooffitt (1998 pg. 14) is defined as:

The study of recorded, naturally occurring talk-in-action....principally to discover how participants understand and respond to one another in their turns at talk, with a central focus being on how sequences of interaction are generated. To put it another way, the objective of CA is to uncover the tacit reasoning procedures and the socio-

linguistic competencies underlying the production and interpretation of talk in organised sequences of interaction.

Thus the ethnomethodological principle has been extended to look at the structures of talk including, how people take turns, negotiate overlaps and interruptions, how conversation is opened and closed and how laughter is organised (Heritage 1997). A central feature of conversation analysis is the idea that people are attuned to the rules, that certain situations and points in the conversation require particular types of utterances. Referred to as *preference*, it rests on the notion that some utterances will be normatively favoured more than others. In addition there are also a number of conventionalised principles which speakers follow including, the mechanism for turn taking, taking or giving up the floor and gesturing patterns which mark the end of a turn (Sacks, Schegloff and Jefferson 1974). The fundamental issue in the study of conversation is that people are able to interpret the principles of interaction and can act on this tacit knowledge. Garfinkel (1967) suggested that without adherence to these principles, people would be unable to interact effectively and navigate their way around social interaction. Conversation then involves the use of a range of procedures and cues, which enable people to make sense of the situation and make social interaction tenable. Individuals thus act according to the rules of conversation in the management of interaction and therefore must be competent for the interaction to be intelligible. Therefore language follows particular patterns, as individuals tailor their talk to the other person (Psathas 1995). A further perspective is offered by Woofit (2001 pg: 49) who suggests that conversation is a site for “social action”, in that “people do things to each other when they talk”. Language is therefore performative, in that it performs certain actions. Talk is organised to perform certain tasks.

For example, Kitzinger and Frith (1999) studied the way that women reject unwanted sexual advances and in doing so, attempt to reduce embarrassment that a refusal would normatively produce. With the use of pauses and “hedges” such as, “well” to produce a delay in the response and palliatives such as, “that’s awfully sweet of you”, the women manage the interaction to avoid the implication that the request is unattractive (Stainton Rogers 2003). The way that the refusals are received demonstrates a tacit understanding of how talk is organised. The data demonstrates how people are attuned to the subtle nuances in the interaction and recognise in advance when a refusal is about to be delivered.

3.6 Discourse Analysis

Just as the definitions of “discourse” vary, so we see variations on the explanations of discourse analysis. The analysis of discourse, at its most simplistic level is defined by Fasold (1990) as, “the study of language in use”. But Brown and Yule (1983 pg. 1) take this further by drawing attention to the functional aspect of language:

the analysis of discourse is necessarily the analysis of language in use. As such, it cannot be restricted to the description of linguistic forms independent of the purposes or functions, which these forms are designed to serve human affairs.

It is an extremely diverse research method that has been applied across a range of social and health sciences and is a popular approach adopted which has been by feminist researchers (see for example Burman 1992; Gavey 1992; Chesters 1994; Crawford et al 1994; Wilkinson & Kitzinger 1995; Kitzinger and Frith 1999). Discourse has been studied from a range of perspectives, spanning conversation analysis (Goffman 1981), ethnomethodology (Garfinkel

1967; Weider 1974), semiotics (Hodge & Kress 1988), socio-linguistics (Tannen 1981), post-structuralism (Foucault 1970), Bakhtinian research (Billig 1997) and critical discourse analysis (Fairclough 1995), each differing in the understanding of “discourse” but nevertheless making a significant contribution to the understanding of “language in use” (Fasold 1990). The various perspectives utilize a wide range of data such as interviews and focus groups as well as historical and contemporary documents and texts. The approach adopted for the study of talk is ultimately influenced by the type of data being collected, the topic under investigation and the academic discipline being used as a reference point for the research (Wetherell 2001).

It is unsatisfactory to give the impression that each discipline is defined by specific boundaries, which tightly delineate the approaches. Indeed many studies have used more than one form of data and adopted a blend of approaches (Mehan 1996). Discursive psychology for example is described by Wetherell (2001 pg: 382) as a “hybrid” approach, drawing from the traditions of conversation analysis as well as Bakhtinian and Foucauldian ideas. Potter (2003) comments that discursive psychology lies between method and paradigm. The focus for discursive psychology is as Potter (1997 pg: 146) defines it, the analysis of “texts and talk as social practices” and as such is an analysis of what people do when they interact.

From this perspective language should not be considered merely as a transparent medium for transmitting information. Instead we see a requirement to view it in terms of the social, political and cultural purposes it serves. The protagonists in discourse analysis see the interplay between language and social processes and its effects in both reflecting and shaping the social order. What counts as reality is a social product that is achieved and sustained by communication. That is, versions of the social world are produced in discourse and it is this

production that serves to constitute situations and objects. Therefore research in this area offers the opportunity to study this constructive process.

For example, Potter and Wetherell (1992) set out to analyse racism in New Zealand by looking at how white New Zealanders make sense of their own history and actions towards the Maori people. The research focuses on how categories and groups are constructed as “the other” in a way that justifies unfair treatment and exploitation. The authors suggest that taken for granted or common-sense explanations are utilised to almost sanitise racist ideology. The racist discourse gleaned from conversation with ordinary people rather than the obvious bigots and extremists, demonstrates how discourse functions to legitimise attitudes and behaviours and thereby structuring society to allow the other to be devalued. According to Wodak (1997 pg. 59) racism is a social structure of oppression rather than an individual opinion about others, but as she points out, social structures would not exist if they were not constantly produced and reproduced by individuals in everyday life as part of their ordinary reasoning.

Potter and Wetherell (1992) find traditional approaches to the investigation of racism problematic, in that the research methodologies overwhelmingly focus on individual attitudes towards other races (see for example Marsh 1976; McConahay 1985). As attitudinal research relies on an “object” on which to base the evaluation, it necessarily assumes that there is a shared and objective understanding of the object being evaluated. So for example, if the research participants were asked to express their feelings towards, in the case of Marsh’s (1976) study, “coloured immigrants”, it implies that the term is a simple category label for a group of people and that there is broad agreement on its precise meaning.

Critically discursive psychologists take issue with the experimental method on a number of bases. Firstly it fragments attitudes and it treats them as discrete entities. So in the example of racism it locates the problem within a kind of faulty thinking, not the very complex phenomena that it is. Secondly, attitudes tend to be studied at the individual level as if existing in individual minds. Most importantly Potter and Wetherell highlight the variability in attitudes, in that people commonly lay claim to attitudes that are polarised. Again looking to their study of racism in New Zealand many of the individuals interviewed expressed conflicting ideas, variability which traditional attitudinal research cannot cope with. Lastly, attitudinal research ignores what question of what the attitudes are for, or more plainly, what people do when they express them (Stainton Rogers 2003). This perspective offers that when individuals express an attitude they are at the same time, justifying behaviour or policy. This is evident in the work of Kitinger and Frith (1999) in relation to dealing with unwanted sexual advances. The authors demonstrated that when men do not acknowledge the refusal of an advance and instead pursue their requests, they are at the same time justifying this pursuit. In sum, attitudinal research treats attitudes as the expression of an enduring internal state, of what someone thinks. However, in the light of the above criticism it is difficult to treat them as anything other than situationally specific and expressed for a particular purpose.

This more complex consideration points to the idea that when people express an attitude they are not just expressing an internal state of mind or describing, in a neutral way, objects and events. They are doing a number of things, and in particular they are attributing a range of characteristics to the objects under discussion. These attributes while frequently presented as natural and firmly based on “reality”, are simply a reflection of cultural knowledge. In addition this knowledge is considered to be accurate and superior in the light of

contemporary ideas. However, these attributions are merely, according to Stainton-Rogers and Stainton-Rogers (2001) constructions that are made to seem real while at the same time attend to a range of such as stake, blame and blame (see for example Locke and Edwards 2003).

Authors such as Coward (1984) and Wodak (1997) have highlighted the way in which discursive practices function to construct women as a distinct entity. In a similar way to racist discourse mentioned above, common sense ideas on the nature and role of women have served to naturalise the notion of a prior feminine identity. Moore (1988) for example explores how cultural understandings of the category “woman” have changed and at each “time” this contemporary knowledge has been considered real. It is not within the remit of this thesis to dwell on the question posed by Simone de Beauvoir in 1949, “Are there women really?” and to attempt to investigate the validity of the arguments for *female* as a biological disposition or as a social nature. The question centres on the imbalance of power, which stems from that ideology and the way that male dominance has become naturalised within key social institutions where masculine is privileged within a patriarchal hierarchy. As in the research conducted by Potter and Wetherell (1992) on the naturalisation of racist attitudes and behaviours, the emphasis is on the way that individuals working in the capacity of Lipskey’s “street level bureaucrats”, represent the social institutions by reflecting and cementing particular cultural constructions. In the case of this thesis the concern is how service providers construct informal carers in the light of their common sense reasoning on a prior carer identity, in an environment in which female is normative.

The focus of this thesis is to explore the extent to which gender norms have become institutionalised within the field of community care. This research seeks to investigate how

the normative evaluations of the informants' everyday talk construct and position informal care as a gendered activity.

3.7 Sample Selection

For Hollway (1989) the goal of social science has been to predict and control, in order to permit the testing of a hypothesis that will ultimately allow mass generalisation. However, the method of discourse analysis is concerned with the idea that all interaction is potentially meaningful and therefore socially important and thus Potter and Wetherell (1987) argue that sample size is no determinant of success. Accordingly Hollway specifies that:

My basic contention is that a social theory of the subject implies that the information derived from any participant is valid because that account is a product (albeit complex) of the social domain. If this domain is analysed in its specificity, the resultant interpretation will be valid without the support of statistical samples; that is, without evidence that whole groups do the same thing. (Hollway 1982 pg: 183)

The central point of such studies is to investigate the part that discourse plays in the construction of social life and for this reason there is no pre-determined ideal. Within this context findings are not generalised to whole groups but to theoretical propositions. Kvale (1996)) therefore suggests that as studies of a qualitative nature generate a large amount of data a sample size of 15 plus or minus five is satisfactory. Potter and Wetherell (1987) contend that discourse analysis is particularly labour intensive and a large sample can render data unwieldy and confusing. For them, ten interviews may provide as much valid data as a much larger sample with data collected via a survey. The crucial point is that the discourse

analyst is interested in language use, rather than the number of people generating the discourse. Indeed useful studies have been conducted from a single text (see for example Potter et al 1984; Wetherell 2001).

The sample for this study totalled 12 informants, and comprised six social care managers and six district nurses. All of the six district nurses were female and three of the social care managers were male. Indeed all of the district nurses in the geographical location are female while a greater proportion of the social care managers in the region are male, reflecting national trends. They were selected on a criterion basis in that the district nurses should have an RGN and a post-registration qualification in community nursing. The social care managers would have the minimum qualification of CQSW. Community nurses and social care managers are key workers in assessing the needs of individuals receiving community care services, the greatest degree of interaction and experience with informal caregivers and have a high level of control in terms of the allocation of resources. According to Worth (2001) district nurses form the largest group of community nursing staff and are the chief providers of care to clients in the community. Social workers as social care managers are key actors in assessing the needs of clients requiring social care. These factors were key criteria in choosing participants, which could be called upon to provide accounts which fit with the overall aims and objectives of the thesis. There is potential within the very broad structure of health and social care to conduct research examining the construction of gender in informal care. Data could be derived from any numbers of stakeholders with an interest in informal caregiving. For example, Chapter one focused on the interests of policy makers in changing the ideological, political and economic landscape of health and social care delivery. Useful studies could be conducted from a sample made up of policy makers as a means of examining their constructions of caregiving. However, this thesis is concerned with gendered

their constructions of caregiving. However, this thesis is concerned with gendered constructions of caregiving at the service interface, primarily because it is at this level that policy is enacted and made real. Its focus is on how *practitioners* account for gender in informal caregiving.

Clearly community care service provision has expanded to encompass a very broad range of practice level staff. Care delivery has been delineated horizontally, in as much as it has become segregated according to tasks. See for example the construction of health and social care as separate spheres within partitions around specific activities. Further, care delivery is also organised vertically whereby roles and responsibilities alter according to the levels of the professional hierarchies. As a result practice level staff operate within a framework, which intimates their function. Hence practitioners with professional qualifications would have responsibilities, which encompassed the assessment of need and subsequent decision-making regarding the extent of service provision. Although samples could be constructed from community care staff with significant practical involvement in care delivery, a sampling frame limited to practitioners with direct responsibility for decision-making would yield data from which valid conclusions could be drawn. This is an accepted method of sampling which according to Mason (1996 pg: 93-94 cited in Silverman 2000) means:

Selecting groups or categories to study on the basis of their relevance to your research questions, your theoretical position and most importantly the explanation or account which you are developing.

All six of the community nurses were female and two of the social care managers were male. Indeed all of the community nurses working in the geographical area were female. A greater

proportion of social care managers in the region were male, reflecting national trends in social work. Mason (1996) gives an example of a study involving discourse analysis which examines gender relations and suggests that it is inappropriate to sample populations on the basis of gender or ethnicity as how these attributes in themselves are defined are topics for research. Furthermore we are unlikely to perceive the world in terms of a large set of gender relations which one can draw a representative sample of people by gender.

The informants were recruited to the sample following a presentation of the outline of the project at their respective monthly staff meeting. Potential informants expressed an interest with a show of hands, which was followed up with the collection of names. However, the show of hands was far from magnanimous, evidencing a possible reluctance to be the research “subject”. According to Silverman (2000) research is often a forum for power relations whereby the social scientist is the King or Queen and the informants are the “dopes”. For Hammersley and Atkinson research is dependent upon:

whether or not people have knowledge of social research, they are often more concerned with what type of person the researcher is than the research itself. They will try to gauge how far he or she can be trusted, what he or she might be able to offer as an acquaintance or as friends, and perhaps how easily he or she could be manipulated or exploited. (Hammersley and Atkinson 1983 pg: 78)

Further, Silverman (2000) draws our attention to the barriers created when “top-down” access is provided. Initial contact with the informants was made through the Directors of the services, which in hindsight may have been a significant factor in the reluctance of the informants to become involved.

3.8 Ethics approval

Approval for the project was granted following the submission of the research proposal to the Director of Primary Nursing and the Director of Social Work respectively. As the focus of the research centred on practitioner accounts of informal care and the method of data collection was likely to utilise tape recordings there were clear issues concerning confidentiality of patient information. To address this the research proposal was submitted to Tayside Committee for Research Ethics. Following consideration by the Committee, ethics approval was deemed unnecessary in this instance, save for the usual measures taken to maintain confidentiality in the disclosure of patient details and the protection of the identity of the informants themselves.

3.9 Data Collection

Discourse analysts take issue with the traditional positivistic paradigm that has pervaded attitudinal research studies insofar as such studies generally seek to decontextualise data to produce clear patterns. Thus attitudes are considered to be enduring objects, but for Potter and Wetherell (1987) it is the context and the variability in accounts that should be the focus of research. Discourse analysis draws on the idea that any interaction is designed by communicators to address goals that are particular to the situation. As descriptions are particular to specific situations, discourse analysis provides the ideal tool in that it allows the exploration of accounts to reveal the paradoxes and inconsistencies that are a natural part of communication. As Schegloff (1995) indicates, attitudes need to be considered in the context of what people are doing with them and not just how they are expressed on an attitudinal

questionnaire. Therefore discourse analysis works on the idea that the interview is not a neutral field whereby attitudes and opinions can be generated and rated according specified outcomes. The point of emphasis lies on the interaction between the interviewer and interviewee and how the detail of interaction relates to the activities being formed (Potter 1996). Therefore no attempt is made to remove the interviewer from the generation of data and indeed their role is more interventionist.

Discourse analysis has tended to hinge on data collected through naturally occurring talk, which in its ideal form, would have occurred independently of the researcher and would not have been “set up” as in an interview situation. This form of data is thought to be ideal because it would be unaffected by the presence of the researcher and the tape-recording equipment. However, this presents a number of problems, both technical and ethical (Taylor 2001). As a result interviews are commonly used and can still be considered to provide useful data. They are generally conversational in style and the informants response are unrestricted.

Informants were contacted by telephone to arrange an appointment for the interview. Brief details were given on the general focus of the research. The interviews were conducted privately within the informants’ offices and were tape-recorded using a hand held device. The interviews were conversational in style but with the assistance of a topic guide to act as an aide memoir to enable some topic consistency (see appendix 1). Following a review of the literature and the identification of gaps in existing the knowledge base, together with a clear understanding of the methodological issues concerning discourse analysis, a topic guide was produced as a means of directing discussion towards the research questions. Some of the questions were not explicitly in place as a means of generating data but were aimed at putting the informant (and interviewer) at ease and creating conditions that would facilitate

comfortable interaction. The intentions were to move the informants comfortably towards discussing their involvement with informal caregivers. After a small number of interviews the topic guide was not required.

3.1.0 Data transcription and analysis

Potter and Wetherell (1987) highlight the difficulties that the transcription of data poses. They conclude that the type of information required from the interview transcript ultimately determines the level of detail recorded. Accordingly Taylor (2001) comments that conclusions can be drawn on the focus of the analysis by what is included in the transcription. Therefore research recording timing, intonation and overlapping of simultaneous utterances suggests that these features of talk are meaningful to the research questions. Such features tend to be found within the conversation analytic paradigm as they reflect the research goals of uncovering “the tacit reasoning procedures and socio-linguistic competencies underlying the production and interpretation of talk as organised sequences of interaction” (Hutchby and Wooffitt 1998 pg: 14). Potter and Wetherell (1987) suggest that such fine levels of transcription are not necessary to many research questions and can adversely affect the readability of data. As Ochs comments:

A transcription that is too detailed is difficult to follow and assess. A more useful transcript is a more selective one. Selectivity is to be encouraged. (Ochs 1979 pg: 168)

However, this selectivity remains a point of contention. Epistemological tradition within research emphasises objectivity but selectivity evidences the role of the analyst in selecting

what is of interest. This creates some difficulty for the analyst and brings into question the status of the knowledge. Taylor (2001) citing Billig (1999) ponders to what extent the detail of transcription is used to foster the impression of detachment and objectivity, a very detailed transcription working to increase the status of the knowledge. If research questions are not concerned with talk-in-interaction, then the fine-grained transcription brings little to the analysis. Indeed it is an unnecessary expenditure of time and money and can make analysis very difficult.

Potter and Wetherell (1987) advise that there is no mechanical procedure for the technique of discourse analysis. Data analysis under this methodological tradition is a reflexive activity in that text is selected according to the analyst's agenda, values and interests. The selected text is the focal point of the analysis with discussion provided on extracts and conclusions drawn. Following the logic of social constructionism, transcribed text is viewed as artefactual, in other words, as a product of human workmanship. Textual artefacts are thus constructed through talk, transcribed from recorded interviews and dissected in relation to the specific research questions set by the researcher. Therefore discussion around data analysis should not within this tradition, centre on what the researcher does as a, "faceless technician" following a procedure in analysing the data to see what is *there* (Taylor 2001 pg: 17). The problem of approaching data as something that has an independent "inner" existence from the "outer" world of the analysis is that it imposes a false dichotomy. This separateness or division stems from an epistemological position embedded within the subjective/objective debate, which obscures the constructive nature of the analysis. Instead from the discourse analytic tradition, not only is the informant's talk action oriented, the analysis is also (Potter and Wetherell 1987).

A variety of computer packages have been developed to assist with the analysis of transcribed text. Programmes such as CAQDAS, NUD.IST and ETHNOGRAPH offer the facility to retrieve relevant extracts such as particular words and phrases or word strings. This can be time saving when analysing large volumes of data (for an overview see for example Seale in Silverman 2000). However, such packages can be considered unsuitable and unnecessary for the discourse analyst who deals with relatively short extracts of text and whose main focus is on the consideration of meanings. Moreover such tools may set limits to the body of data. As Seale (2000 pg: 165) comments many researchers need to “think hard about the meaning of data” and computer packages are no replacement for this. Indeed such programmes while excelling at the retrieval of particular words or phrases, offer little to the discourse analyst whose focus is not merely on the words used. Therefore computerised packages were not used in the analysis of data generated for this thesis for the reasons given above.

Tape-recorded data from each interview were transcribed verbatim onto a word processor. As the research questions were not concerned with phenomena such as pause lengths, hesitation, overlaps and intonation these features were not transcribed as they were not crucial to the type of analysis selected and could make reading difficult (Potter and Wetherell 1987). The focus of the research was to centre on the variety of repertoires in use and the way that they were rhetorically managed and therefore the Jefferson method of transcription was not employed. Transcription encompassed both the questions posed by the researcher and the informant’s answers. There is no step-by-step procedure for analysing data with this methodology and indeed Potter (1996) describes it as a “craft skill” that involves critical interrogation. Instead the discourse analyst employs a broad theoretical framework, which takes note of the construction and function of accounts.

Analysis of the data occurred over several weeks and began with transcription and several readings. However, as is usually the case it was not immediately apparent what topics would be of interest and what exactly was being uncovered. After several readings, sections of talk that appeared to be significant were underlined with coloured pens and notated in the margins as a means of coding. From this patterns began to emerge, which hinted at common linguistic resources and interpretative repertoires as well as issues concerning stake and interest. These avenues were explored in other transcripts and broad theoretical categories began to emerge. At the same time frequent reference was made back to the research questions, as some of the categories although interesting, did not relate to the focus of this study. Thus the analysis involved immersion in the data to identify both the construction of gendered identities and the “management” of the accounts. Extracts from interview data are numbered, with the interviewer’s talk notated as “Interviewer” and the informants’ as “Informant”. Each informant is coded and numbered as either DN for District Nurse or SCM for Social Care Manager.

A suggested earlier, discursive psychology draws from a number of traditions with different methodological concerns. Within the conversation analytic tradition the researcher is a neutral observer, describing what people do in the organization of their talk. Here researchers are not explicitly socially concerned within the context of the research. The other extreme is that of critical discourse analysis where the researcher is a social critic who is overtly motivated to uncover social or political problems and open them up for debate (Wetherell 2001). Debate therefore centres on the extent to which the analysis of data should be woven with an analysis or commentary on the social, historical or political implications of what is being said. Should data be afforded an autonomous status or should it be treated as being situated within a

broader social framework? While conversation analysts would be concerned with the structure of the talk as an object of study, the discourse analyst would be inclined to look at the meaning of the words used and their connections perhaps to other conversations, political statements or documents. As Wetherell (2001 pg: 390) comments “there are no clear demarcations where discourse stops and the rest of social life begins”. It is therefore difficult to sustain boundaries around the talk and things external to the talk, as the two are inextricable. Thus the analysis adopted in this thesis takes the approach of a discussion around the discursive history and political context of the talk.

3.1.1 Validity and Reliability

For Hammersley (1990 pg: 57) validity refers to “the extent to which an account accurately represents the social phenomena to which it refers”, while reliability is defined as ‘the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions’. Thus these key concepts in research centre on convincing the reader that the findings are based on an accurate reflection of the data. “Good” research is therefore considered to be value-free, leading to a universal truth. It is objective and thus separate from the researcher (Wetherell 2001). However, an alternative perspective, particularly in relation to the tradition underpinned by social constructionism suggests that research findings are an interpretation and as such are a mere version of events, which according to Wetherell (2001 pg: 11) is “inevitably partial”.

For Wetherell, “findings” are inextricably related to the researchers own values and world-view and thus claims to objectivity should not be made. Indeed it could be argued that with discourse analysis the data is entirely subjective, as what counts as data is contingent upon

the theoretical assumptions of the researcher. Material has been actively selected for its relevance to the research questions and from this perspective we should conclude that as what counts as data, is influenced by the researcher, it may then be the same of all knowledge regardless of the method of generation. As mentioned earlier, discourse analytical research is “situated”, in that it refers to a particular time and place and therefore cannot be recreated and replicated to reveal universal findings. This issue of reflexivity is central to this alternative tradition, which acknowledges the non-neutrality of research and that findings do not represent a collation of facts as a “single external reality” (Seale 1999 pg: 41). Attempts at objectivity by constructing a representative sample, using a “better” method of data collection and analysis will not, within this tradition, produce more reliable findings or reveal “the truth”.

This thesis, as an account of the construction of gender in informal care, is itself a construction as firstly, the researcher cannot separate him or herself from the research, and secondly, the material is specific to the context. Despite arguments which undermine the concept of objectivity, Phillips and Pugh (1994 pg: 117) suggests that a common experience in the field of feminist research is that students are taught that within the traditions of their field of study, “there is no such thing as objectivity”, only to find that as post-graduate researchers, they are frequently criticised for not being objective. Indeed it is worth noting that research methods that are subjective are frequently used by women and in particular women with a feminist consciousness. Therefore both subject and method becomes areas of struggle.

As discourse analysts do not make any claims to objectivity, Potter and Wetherell (1987 pg: 182) comment that perhaps discourse analytic researchers are “simply more honest than other

researchers” in recognising the subjectivity of their own work. It is important therefore to be explicit in stating the ideological assumptions, which underpin the research and to view any analytic themes as a joint venture between the informant and the researcher. In this sense the analysis contained within this thesis is about the events and situations described by the informants and at the same time it also part of it, in that it does not lie outside the data. Potter and Wetherell (1987 pg: 183) suggest that as researchers we should put these concerns to one side and “just get on with it”. This view is supported by Gill (1995) with the caveat that the researcher’s values should be acknowledged and revealed and should therefore be clearly recognisable as feminist, commenting that feminists have always been interested in the connection between language and oppression.

Despite this stance there are techniques, which can be used to validate the research. Firstly the analytic claims should be coherent in that they should present a tight case for the findings. The analyst must demonstrate using the text, convincing examples of how the discourse supports the explanation. A second method of validating discourse analytic research concerns the issue of how the informants themselves recognise inconsistencies, variability and potential challenges in their own accounts. It has been previously mentioned that variation in accounts is of interest to the researcher, but it can also serve to demonstrate the validity of the claims being made when the informants themselves have recognised it and engage in attempts at repair. A further criterion of validity concerns fruitfulness in that the analysis should generate fresh ideas and make unexpected discoveries. However, these criteria are not infallible and as mentioned in an earlier section, discourse analytic research is grounded in the subjectivity of analysis. For Potter and Wetherell (1987 pg: 172) “infallible criteria exist only in the land of positivist mythology”.

3.1.2 Generalizability

The previous sections have dealt with the subjects of sample selection, validity and reliability and have commented on the difference in the analytic claims made by discourse analysts as compared to other researchers. It is generally not the case that claims are made for mass generalisation of research findings within the discourse tradition. According to Perakyla (1997 cited in Silverman 2000) the basic structures of the social order are to be found anywhere and thus if we look to any case we will find the same order.

Social practices that are possible, i.e., possibilities of language use are the central objects of all conversation analytical case studies on interaction in particular institutional settings. The possibility of various practices can be considered generalisable even if the practices are not actualised in similar ways across different settings. (Perakyla 1997 pg: 215)

This argument is influenced by Sacks (1984 pg: 22) who states that the “machinery” of communication pervades interaction and within this context suggests that we can “tap into whomsoever, wheresoever and we get much the same thing”. The point is that the results of investigations into conversations should be the same because we share linguistic structures and resources. Indeed Sacks uses the example of a child learning a culture from a very limited range of contacts. Thus as Perakyla (1995 pg: 214) comments that, “the results should be generalizable to the whole domain of ordinary conversations...” as individuals draw upon common knowledge of talk and interaction. It is this stance that supports the research involving single cases. Silverman (2000) supports the generalisation of findings to theoretical

propositions rather than to populations. Alasuutari suggests that generalizability may be a misnomer in relation to qualitative research.

Generalization is[a] word that should be reserved for surveys only. What can be analysed instead is how the researcher demonstrates that the analysis relates to things beyond the material at hand*extrapolation* better captures the typical procedure in qualitative research. (1995 pg: 156-7)

The findings of this research will therefore be “generalizable” because the sample is theoretically grounded in that the groups have been chosen for their relevance to the research questions. In addition analysis will involve the identification of patterns or features, which are common to interactions outside the field of the research, such as rhetorical features and the management of “face”. Commonalities will also be identified in the particular groups, for example, the district nurses having a shared form of accounting evidencing very similar interpretative repertoires.

3.1.3 Rationale for research questions

Reflecting back to section two we identified several gaps in the existing knowledge base relating to the taken for granted assumptions of service providers in community care. The intention of this thesis is to focus on the area of the construction of gender in informal care. Within the literature review seminal empirical contributions were identified and their research approaches noted. The epistemological gap within this body of knowledge relates to the characteristics of language in the form of linguistic resources and the processes and agendas which sit behind them. The ontological approach specified is that of social constructionism

and this informs the specification of research questions for the thesis. The research questions are presented below:

3.1.4 Research Questions

1. How do service providers construct versions of the informal carer?

To identify and characterise the linguistic resources of distinctive groups of community nurses and social care managers. Seeking to define the ideologies at work in talking about objects and events in the care context.

2. Which interpretative repertoires are used by service providers in the evaluation of informal carers?

Evaluating the flexible deployment of language in order to specify and analyse the range of rhetorical opportunities open to service providers within the context of evaluation.

3. How are the interpretative repertoires used to position informal carers?

That is to say how are informal caregivers personified and assigned particular attributes and how these subject positions are located within talk.

4. What differences and commonalities can be identified in the interpretative repertoires of community nurses and social care managers?

To investigate how the discourses and linguistic methods of the two sample groups compare. What policy and educational implications arise from the findings?

5. How to service providers describe needs assessment and how does their accounting of this process incorporate gender assumptions

To investigate the range of discourses used to describe the incorporation of the caregiver into needs assessment.

6. How do informants deploy linguistic techniques to protect social and professional identity?

To investigate the performative aspects of language in that language is used for a variety of purposes. How do the informants manage their responses in ways that minimise the risk to professional identity?

As we have seen research from Finch and Groves (1980), Qureshi and Walker (1988) and more latterly Bauld et al (2000) has demonstrated that women predominate in informal care. 72% of principal informal carers are women and and possible explanations have been offered, centring on the construction of caregiving as a female activity. Women, it is argued are co-opted into caregiving because of the normative expectations of community care practitioners. For the discursive psychologist these normative expectations are produced from the “commonsense” ideas or conventional stock of knowledge on the nature of caregiving. It has been argued in previous sections that discursive psychologists see masculinity and femininity not as fixed in a biological deterministic sense but as constructed by the range of available discourses in circulation. Gendered identities are therefore pathologised by the way that people talk about what it means to be a man or a woman. This research study seeks to investigate the how practitioners in community care construct informal care from the range of linguistic repertoires available to them. Edley (2000 pg: 198) argues, “when people talk about things they invariably do so in terms already provided for them by history”.

Data has been collected through open-ended interviews with district nurses and social care managers. A framework of questions can be seen in Appendix 1. The practitioners, as a response to the interviewer's questions are describing informal care and are illustrating their points with examples from practice. Analysis identified a number of key themes or resources that can be drawn upon to construct and position informal care.

3.1.5 Structure of the analytic chapters

This thesis comprises four analytic chapters. Each chapter is structured on the basis of the key themes that have emerged as a result of careful analysis. These key themes essentially represent the conventional stock of knowledge on both caregiving and gender. As such they highlight to the reader the available linguistic resources that informants tap into when discussing caregiving or when justifying particular ways of talking about caregivers. Each of the subheadings attempts to capture the essence of the stretch of talk and subsequent analysis. Again each chapter could have been ordered differently and structured in other ways, however, decisions were made on the internal structure on the basis of what was most appropriate and most interesting (Taylor 2001).

Chapter four demonstrates how caregiving is constructed as a natural element of feminine identity but paradoxically within a context of equalities talk. In addition analysis also turns to the management of informants' accounts for the protection of their professional identity. Chapter five uses the same analytic techniques to highlight the construction of masculine identity in which caregiving is heavily socially proscribed. As with the previous chapter attention is also paid to the informants' deployment of linguistic resources in the management of the accounts.

Chapter six centres on the construction of success in informal care and considers the means by which it is exemplified both positively and negatively. However, these evaluations are shown to be connected to the gender of the caregiver, as well as to the relationships between the carer and the recipient. Chapter seven is a shorter analytic chapter focusing on the assessment of need and how the assessment “process” is constructed as value free activity. This chapter argues that assessment can be used as a vehicle to carry commonsense assumptions on gender.

The final chapter draws the previous chapters together and makes conclusions for the thesis. The focus centres on why and in what way the thesis has contributed to the existing body of knowledge in relation to gender and informal caregiving and identifies implications for policy and practice.

The structure of the analytic chapters and their content could have been ordered differently. Indeed initial attempts were made to order the chapters around each research question. However, this proved problematic, primarily because of the potential repetition of data extracts. For example, an analysis of one extract would reveal the use of interpretative repertoires (research questions two, three and four), while at the same time demonstrate the management of stake and interest (research questions one and six). Chapter ordering by research question would have meant presenting the same data extracts several times, which would have increased the volume but would have potentially diminished the quality of the finished project. Therefore each extract of data is analysed and the significance is then discussed in sequence.

Chapter Four

Female Identity

4.0 Introduction

This chapter utilises the method of discursive psychology previously detailed and with extracts of data collected from the two sample groups, examines the construction of female identity in talk. The analysis draws attention to the construction of caregiving as a core characteristic of the feminine identity and reveals a range of ideologies, which the informants' use to furnish their accounts. Data are also presented to demonstrate the variability and contradiction in the accounts and the use of linguistic techniques, which attempt to create distance between the informants' and the ideas being expressed. The analysis is guided by authors such as Potter and Wetherell (1987), Potter, Edwards and Wetherell 1993), Potter (1996) and Goffman (1967) in relation to the study of language as social practice. The position within discursive psychology holds that the interviewees (hence forth informants) are not giving accounts of their attitudes towards informal caregivers but are instead constructing versions of informal care through their descriptions and evaluations.

4.1 Conventional perspectives on gender

Social anthropology has demonstrated the varying ways that cultures understand what it means to be a man or a woman (Mathieu 1989). However, certain commonalities appear across the different societies in the form of stereotypes and sexual ideologies. For example Ortner (1979) asserts that to be a woman in any society is to occupy a secondary status. Several theories have been proposed to explain this inequality. Searching for the thread, which links this “pan-cultural” subordination, she suggests that it is woman’s reproductive function and domestic role that makes her appear closer to nature and therefore of less value. This association with the natural world devalues women, as nature is seen as base and uncivilised. Men however, are associated with culture, which according to Ortner is regarded as superior for its attempts to transcend and control the physical world. These differences can be set in opposition to each other and can aligned to other sets such as “up”, “right” and “strength”, which characterise culture and maleness. While women are characterised in terms of nature with, “down”, “left” and “weakness” (Moore 1994 pg. 16). Thus men are regarded as rational while women are thought of as irrational and it is therefore natural for women to be controlled and contained.

These apparent differences have supported the norm of male superiority by emphasising a type of female personality structure, which is better suited to an economically non-productive environment. Until fairly recently research into gender has focused on the examination of the psychological differences between men and women and the findings

have been used to provide credence for gender inequality (Lott 1985; Morawski 1985). Other inquiries such as that of Chodorow (1978) and Gilligan (1982) have sought to validate gender differences as a range of positive and essential attributes, which provide men and women with unique capacities for specific tasks. Such assertions, which emphasise women's differences from men, have worked to weaken the cultural devaluation of women and have in some ways supported the aims of feminism. The essentialist theories, particularly that of radical feminism has a mixture of claims, one of which being that women are culturally superior to men. For example, the physical capacity to bear children is seen to endow women with a psychological nature of sensitivity, truthfulness and altruism, while on the other hand, the male personality is seen as ambitious and aggressive, with a concern for justice over care. However, such theories run the risk of generating and reinforcing a stereotyped version of gender identity. This view merely furnishes support for gender inequality, producing the female equivalent of male chauvinism.

Another stance is to minimise gender differences and thus overlook the disparity in the experiences of men and women. From this perspective generalisations are made about human behaviour and development, which necessarily assumes that women's experiences are no different to men's. For example social policies that look to provide equality of treatment for men and women but do not take into account the social and economic forces, which militate against real change. The minimisation of gender difference can also construct a type of psychological androgyny, which masks the disparate needs of individuals and inequalities in power. However the minimisation of differences is not

without its advantages. Equal rights legislation has enabled inequalities to be addressed in some areas, particularly in relation to equal pay and educational opportunities.

However, the view of male and female as dichotomous and fixed identities is a prevailing ideology. The academic gaze has centred on uncovering the reasons for gender differences. Three main approaches have developed namely, socialisation theory, psycho-analytic theory and biological theory. Socialisation theory sees masculine and feminine identities as a result of the reinforcement that babies and children receive in gender attributes. Psycho-analytic approaches focus on early childhood experiences, particularly in terms of the unconscious process of gender identification with parents. So, because of the rich mothering experience a female child encounters it will identify with the mother. A male child however will make a break from the mother and identify with its more distant father. It follows then that a female child will grow up to be more nurturing than a male. Biological approaches explain gender differences in terms of anatomical and physiological differences. Men and women are thought also have to neuro-anatomical differences, which have an impact on spatial and mathematical ability as well as vocabulary and emotion.

However, such approaches have been undermined more recently as attention has shifted towards the investigation of gendered identities as particular social categories, which are constructed through discourse. “Masculine” and “feminine” from this perspective are not fixed entities but are constructed from interaction. Social practices become known as gendered activities through the way that people talk about them. This chapter therefore

explores the ways that service providers evaluate informal caregiving and in so doing construct it as a gendered activity. The analysis is guided by Potter's (1996) view that descriptions and accounts used by informants construct the world and that descriptions and accounts are themselves constructed out of the linguistic resources available. The analysis also offers an insight into the techniques used by informants to make their accounts appear factual and in so doing serve the interests of society by presenting sets of ideas as natural or inevitable. This is performed through a series of questions from the interviewer and responses by interviewees. As discussed in the previous chapter, discourse analysis proceeds on the basis that individuals draw from a range of repertoires and that when doing so they also adhere to a number of conversational rules. That is, they use normative expectations about conversational interaction and effectively manage their encounters to protect against potentially troublesome utterances.

A major concern of the discourse analyst is how reality is constructed through discourse and an important feature of this is the way that objects, events or people are constituted in talk. The realistic perspective on discourse sees language as a mirror of the object, it merely describes what is real or factual. In other words the object appears and the language names it. However from the discourse perspective it is through the act of description that objects are brought into being. Descriptions necessarily involve the categorisation of objects as having specific qualities that define them. Therefore the discourse analyst is concerned with how such categorisations formulate the object and bring it into being. This is not to suggest that categories are fixed and enduring and are shared by all. Instead that they are more liquid and are selected and used in talk to serve

the demands of the moment. Indeed Potter and Wetherell (1987 pg: 137) describe categories as “the building blocks of our many versions of the social world”. However, “reality” is shaped by local practices and it is argued within the context of this thesis that the informants’ descriptions serve to shape or constitute informal care through the use of particular words and ways of talking, which are informed by a conventional stock of knowledge on gender.

The first theme to be considered in this section concerns the categorisation and formulation of women as having a distinctive character, which is suitable for caregiving.

4.2 Women’s instinct and intuition

The introduction to this chapter argued that a number of perspectives support the supposition that feminine identity is oriented towards family work and home life with an emphasis on relational involvement. From a psychodynamic epistemology Erikson (1964 pg: 586) wrote that female identity “harbours a biological, psychological and ethical commitment to take care of human infancy”. Gilligan (1982) echoes this with the assertion that feminine identity is based on the ethic of care and responsibility for others. The informants’ accounts showed a general orientation towards inherent gender differences in informal care, many making reference to women’s disposition towards care-taking roles by reason of their nature. See for example the following extract.

Extract (1)

Interviewer: Do you think that women are born with a natural ability... [to provide care]?

Informant DN 1: I think so, yeah, I think so. I mean a lot of feminists say, “oh no we’re equal”, and we are equal, but I think there’s more attributes in female attributes, and I think females (inaudible) is a bit of nurturing and caring, and I mean there’s nothing wrong with that, there’s nothing wrong with that at all, and I mean some men who are wonderful carers, em, but it’s different. A woman will, I think she’s more practical you know. It’s kind of an instinct you know.

A number of issues can be drawn from this stretch of talk to highlight some of the concerns of the discourse analyst. Firstly as detailed in the methodology chapter the interview as a method of data collection within the discourse analytic paradigm is seen as a conversational encounter and not as a method of tapping into the unbiased opinions of the interviewee. The interviewer’s questions as well as the responses they generate become a focus for analysis. This is because the researcher cannot be separated from the research and thus their input has to be acknowledged and taken into account. The researcher has to understand their own presence in the collection and analysis of data and how they influence the responses given. Potter and Wetherell (1987 pg: 165) for example comment, “the linguistic nuance of the question is as important as the linguistic nuance of the answer”. Therefore the researcher’s questions will be analysed as having a direct bearing on the accounts provided by the informants.

The interview method of data collection involves a question and answer format to which both parties are attuned, the format being the most basic structure of interaction. The turn order is fixed, the interviewer asks a question and the interviewee responds. The question and answer style is a typical example of what is known within conversation analysis as “adjacency pairs” and is a principle of the organisation of talk in which the first part is produced by one speaker and the second by another. Both parts tend to be bound together as a question necessarily limits the range of responses that can be given. It is designed to elicit an answer and therefore a response of some sort is expected. Although questions are generally explicitly stated, the first response may seek to clarify the precise meaning before the definitive response is given. For this reason adjacency pairs can be ranked according to the responses that are preferred and those that are dispreferred in line with the kind of response the questioner is expecting. Potter and Wetherell (1987) provide an illustrative example of a preferred response to an invitation being an acceptance. An individual may want to refuse an invitation but as this would be a dispreferred response and the norms of interaction would discourage him or her from refusing outright as this would potentially create social embarrassment therefore a refusal is generally managed so as not to cause offence. A refusal then or an avoidance or non-answer would normatively be marked by a delay and would be prefaced with some form of hedge to further delay the answer.

The point of note is that questioners generally expect a particular kind of response and in this extract the questioner has asked a direct question, “Do you think that women are born with a natural ability [to provide care]”? A direct question of this nature serves to limit

the range of possible responses and indeed would normatively be interpreted as a request for a yes or no answer. However a direct question, which asks the informant for an opinion is potentially threatening and therefore requires careful management to avoid a negative evaluation, which could damage their professional and personal identity. We can see in extract (1) that the informant responds with “I think so, yeah” which may be viewed as hedging but is delivered as an immediate response, before the question is completed, marking it as a preferred response. There is agreement in that the informant concurs with the interviewer, but the response is weakened by the hedging. Hedging in question and answer sequences essentially work to suppress any show of feeling before the speaker has had time to judge how their response will be received. In extract (1) the speaker is making a tentative reply to a direct question because it broaches a potentially sensitive issue and invites the informant to make a statement, which could be construed as sexist. We note that after the initial reply the informant moves immediately into an explanation to justify her statement with information about what “feminists say”.

Secondly, the idea of talk as the material of ideology is central to discourse analysis and concerns the way that talk is shaped by available resources such as previous accounts (Fairclough 2001). We see that the informant makes a clear and unambiguous reference to “female attributes” such as “nurturing and caring”. As we have seen from the chapter introduction this is a familiar form of accounting and can be related to a number of perspectives, which propose a female “nature”. Bakhtin (in Jaworski and Coupland 1999 pg: 131) wrote “the topic of a speaker’s speech, regardless of what this topic may be, does not become the object of speech for the first time in any given utterance”. As the

speaker is not “the biblical Adam” dealing with objects that have as yet been unnamed, any utterance has already been the subject of talk. Therefore an utterance, as well as being addressed to the object is also addressed to others’ talk about it. A speaker is one of a chain of speakers who articulate ideas about an object and so utterances are necessarily filled with or informed by others’ words, some of which can be authoritative sources such as scientific or journalistic works. The informant’s account in extract (1), alludes to the idea of a “female nature” and is as Bakhtin suggests, shaped by interaction with a number of speakers who have already set the tone. As the informant has not herself named the object of talk, that is “caregivers”, she is necessarily relying upon others’ accounts or sources.

In addition it is clear that the account is also influenced by a further discourse, that of equality. Again Bakhtian principles apply in relation to the concept of equality. The informant has not authored the term. Instead it has been issued as a link in a chain of others’ utterances. It has been informed by others’ and will itself, become someone else’s.

A further interest of discourse analysis, as discussed in the previous chapter is the idea of talk as being orientated to a particular action. It is designed to certain ends. To illustrate this we can look to extract (1) and consider the utterance “I mean a lot of feminists say, oh no we’re equal, and we are equal” and consider the possible purposes served by such an utterance. That the informant is aware of counter claims, which reject the idea of caring and nurturing as female capacities. Further, the message being conveyed in this

account is that it should not be presumed that caregiving is the sole preserve of women and that in the informant's experience "men can be wonderful carers". So we see that the "views" being presented tap into essentialism and equality, which are in effect two competing ideologies.

This contradiction presents as something of a problem for the analyst in attempting to locate the "true" nature of the entity under investigation and provides an interesting example of the epistemological basis for discourse analysis. The previous chapter discussed the orthodoxy within traditional psychological methods, which typically perceive language to be a conduit for factual representation of internally held attitudes or beliefs. Methodologies advocating the use of this "realistic" perspective on language necessarily suppose that the events being described are as suggested by the informants. But what are we to make of these two contrasting ideologies in terms of the "true" attitudes of the informant.

However for Billig et al (1988) contradictions and inconsistencies are part and parcel of normal every day interaction. Contrary to Marxist definition of ideology, which proposes that the ruling classes dominate through sets of beliefs that come to be accepted as commonsense, individuals rarely have a composed set of beliefs that are enduring and well thought out. In Billig et al's perspective there is no unified commonsense because the stock of knowledge is so diverse. For this reason, opposing values are frequently seen to collide as we see in extract (1). As previously stated, there are many theories of gender in circulation that could be thought of as commonsense, and at the same time there is also

a vocabulary of equal opportunity in contemporary society and so we see accounts where there is an apparent clash of ideas. According to Billig et al these are examples of “ideological dilemmas” in that people have many ways of talking about an object, some of which are contradictory. What is of interest here is the way that informants mix ideologies depending upon the demands of the moment. As accounts typically contain such variability it therefore seems unacceptable to suggest that attitudes can be consistent and enduring.

The informant draws from an essentialist argument that emphasises the notion of women as innately predisposed to caring as a fulfilment of their identity as nurturer. That caring, for women is instinctive. Men may be “wonderful carers” but women are better because it comes *naturally*. The informant seems to be aware of this apparent contradiction and that she may have undermined herself as a proponent of equality and therefore attempts to repair any confusion with “and I mean there’s nothing wrong with that”.

The aspects arising from this short extract of data demonstrates some important issues in discourse analysis. We have seen that caregiving is presented as an activity that is within the capabilities of both men and women but that women’s caregiving is superior because of an instinctive quality. However the distinctive characteristics of women enable a greater intensity and a naturalness, which men cannot provide. Furthermore the informant is orientated towards managing her account in a way that recognises the potential difficulties in her responses vis-à-vis stereotyping.

A similar question and answer sequence occurs in extract (2) evidences whereby the interviewer asks a question, which invites a potentially obnoxious answer.

Extract (2)

Interviewer: Do you think that women are necessarily better at caring than men?

Informant DN 2: I don't think so no. I'm just thinking of a couple, he's not on our case load but he's really... and another one. Their wives have had strokes. One in particular, he's very caring. So I don't think it's necessarily women that make better carers but they have certain qualities, which enable them to care intuitively.

It is interesting to see the use of hedging again in extract (2) with the answer, "I don't think so" to evade a direct response. Note that as in the dispreferred response in extract (1) the informant provides an account as explanation or justification for her stance. The initial stage of the response rejects the idea that "women are necessarily better at caring than me". By replying in this way the informant is seen neither to discriminate against men or women in the debate about who is the better carer. Moreover the account features examples of male caregivers who have been "very caring". However there appears to be equality until we examine this extract in more detail. It seems that the informant is suggesting in a similar way to extract (1), that while women are not necessarily better than men, men have to try. Weaknesses have to be overcome to enable men to be good carers. Women have the advantage in that they have female intuition, which adds a natural quality to the caring.

Note also how the informant provides what appears as to be fairly inconsequential detail on the diagnosis of the recipients of care, commenting “Their wives have had strokes”. A “stroke” in itself is a category that carries with it particular cultural meanings. It is a fairly distinctive condition, with after effects ranging from very mild to severe incapacity and loss of functional ability. Individuals who have experienced a stroke can have varying requirements for care but it is generally associated with a need for personal and physical support. According to Potter and Wetherell (1988) details can allow precise inferences to be made about the activities or objects described. Such details allow the listener to take the position of the person doing the describing, hence we are given details of the diagnosis so that inferences can be made about the level of caring and commitment that the male caregivers had demonstrated. The detail of the diagnoses thus provides a medium to indirectly infer that male caregivers can compare favourably to female caregivers in providing a high degree of support. From this the listener will be inclined to accept the informant’s position on male caregivers and will therefore accept the informant as unbiased (Potter 1996).

4.3 A superior kind of care

Analysis of the previous extracts demonstrates how cultural resources such as “female intuition” and “instinct” can be brought in as a means of supporting the idea that women are better caregivers than men. We have also seen how the informants’ accounts are discursively managed to avoid potentially troublesome answers. The next extract (3) demonstrates further strategies by which informants’ manage their evaluations. The

informant in extract (3) is less reticent than others about offering what she states may be construed as a sexist remark.

Extract (3)

Interviewer: Have you got any cases in mind that stand out as that was performed to a very high standard?

Informant DN4: Yeah. I'm thinking of a recent terminal case and you know just changing position. It seems a very nurse thing to do but it could cause pressure sores and would be painful etcetera and it was understood and every care was taken.

Interviewer: So who was the patient? Was it the husband or the wife?

Informant DN4: It was the husband and it's a sort of sexist remark to make but females on the whole tend to make better carers than men and that might be a gender thing. No I wouldn't, not always because some men take very, very good care. I think some of it's a caring thing from being a mother. But some men do take very good care of their spouses or whatever.

The sequence begins with a request for an exemplar of where care was performed to a high standard. The informant offers an example but focuses on the exemplification of the activities the carer engaged in, such as changing position to prevent pressure sores developing. However the interviewer seeks clarification on the sex of the carer. To which the informant replies that it was the husband and follows with "it's a sort of sexist remark to mark but females on the whole tend to be better carers than men". For Goffman (1967)

this technique is an example of stake confession, which works on the principle of disarming a potential critic. The informant is indicating to the interviewer that they have not said something that they are unaware of and thus the manoeuvre is to confess and thus concede the point.

The informant is just about to say something that may be considered sexist that is “females on the whole tend to make better carers than men”, and it is unlikely that a statement such as this is will go unnoticed. A confession attempts to make what is about to be said unproblematic as clearly to be heard as sexist would be inconsistent with her professional status. In addition qualifiers or hedges are used in the form of “on the whole” and “no I wouldn’t, not always”, as further techniques to avoid being discredited by the accusation of stereotyping (Goffman 1967). The extract ends with the informant remarking that some male caregivers “take very good care of their spouses or whatever”, citing two categories of potential recipients of care, one precise and one vague. What is implied by “whatever”? It has been noted in previous chapters that statistical evidence points to a significant number of male caregivers in the population but that they tend to be involved solely in the care of spouses. The informant’s turn to vagueness with “whatever” could be because men are so seldom to be found caring for people other than their spouse. Of course the main theme of the extract is that in common with the previous extracts, the informant is suggesting women are “better carers than men”, and cites the origins for this as lying again in a natural predisposition for care exemplified in mothering.

4.4 Women's caregiving as the standard

It is clear from the analysis so far that in drawing from pre-existing resources such as female intuition and a caring instinct, female caregiving can be constructed as qualitatively different from care provided by men. In this section we see the use of accounts of informal caregiving that constitutes it as the norm or standard. It has already been noted in earlier chapters that an enduring notion is a “good nurse” being necessarily, the “good woman”. Caring work is predominantly seen as men's work, therefore leaving caring, with its lower status, to women (Skidmore 1994). The following extract (4) evidences this with its constitution of male care as being inferior to female care and thus female care as the standard.

Extract (4)

Interviewer: Do you think there are some underlying assumptions about women and their caring attitude? Is it something that is on the mind of nursing as a whole?

Informant DN2: Well nursing is predominantly female. I think it might be in the minds of the patients. We have a male night sitter and we have to warn them, well not warn them but let them know that he's a man and it seems that as a nurse he's just the same as a woman. The gender stereotype is something to let go of.

The interviewer's question explores the possibility of a universal assumption regarding a female disposition. There are a number of points to consider here and of course we

should also consider what has been said in this extract in relation to the informant's previous utterances. In extract (2) we saw that informant DN2 mentioned that women "have certain qualities which enable them to care intuitively". In extract (4) however the same informant cites gender assumptions as being "in the minds of patients." We see a rejection of the interviewer's charge alluding to possible implication that nursing "as a whole" adheres to stereotypes. The informant plainly shifts the blame for this away from nursing and onto patients. Thus the accountable agent is presented as being "out there", allowing the informant to avoid personal implication.

Secondly the informant mentions how she has to "warn" patients that the night nurse, booked to care for them is male. She recognises that this is perhaps an inappropriate use of "warn", which necessarily signifies danger and quickly tries to put this right. Within conversation analysis this correction is termed "repair" and is essentially a speech activity whereby speakers replace some piece of information with another. In this case the repair has been initiated by the speaker, but in other circumstances repair can be initiated by the listener. The use of repair shows the speaker's sensitivity to their own production of talk and how their utterance, may be perceived by the listener. What the speaker in extract (4) alludes to is that both patients and informal carers would find care administered by a male nurse alarming. This point will be taken up in greater detail in a later section but it is clear that this asserts the normative standard of female care. In addition the informant says, "as a nurse he's just the same as a woman", that again can be viewed as drawing from a repertoire of equality, but we see that its use makes clear reference to a female standard. To be a nurse is to be a woman or to have "female" qualities.

The extract ends with the phrase “The gender stereotype is something to let go of” which is designed as a speech act to portray the informant in a positive light by aligning herself to liberal, educated values, working against those that are old fashioned and outdated.

This adds to the perception of the informant as not someone who would hold stereotypical views about gender.

We have seen examples of inconsistency in the accounts of DN 2’s accounts in extracts (2) and (4). Potter and Wetherell (1987) highlight the issue of inconsistency in accounts, commenting that this is a regular feature of talk. For them an individual’s accounts will vary depending upon the function and orientation of the accounts. That is they differ according to the demands of the moment. So we see this variation between extract (2), which is informed by a stereotype and extract (4), which calls for stereotypes to be retired to the era to which they belong. We can see that this variation is problematic for research, which adopts a realistic perspective on language, seeing it as the means by which researchers can uncover beliefs and attitudes. From the example provided by informant DN 2, where do we locate the belief about gender and caregiving?

On the theme women and caregiving, Graham (1983) examines the emotional significance of the caring relationship to the female identity and suggests that the ability to care is what differentiates female from male. Drawing from the work of Chodorow (1971), Graham develops a distinction between the essentially female state of “being” as opposed to the male state of “doing”. To be female is to be passive, compassionate and

necessarily connected with others. To be male is to have a sense of self, which is orientated towards activity or production enabling men to engage in skilled work. For Graham, women have been forced to use their caring nature as a means of negotiating their way into the labour market (hence the disproportionate numbers of women in care work) and as a way of consolidating their position within the family. While caring is recognised as implicative of an emotional relationship or bond, or as Finch and Groves (1980) suggest a “labour of love”, it can be transformed for the benefit of the capitalist system into a work role. Although analysis of the informant’s response in extract (4) gives clear evidence of an application of a gender norm to caring, in the light of Graham’s account perhaps the male nurse is after all, “just the same as a woman” in that both sexes are engaged in a labour contract, selling their labour in a capitalist system.

We have seen accounts that constitute women as having a “state of being” that enables them to care. However analysis has also revealed that informants are alert to the problematic potential of such utterances and engage in a range of linguistic moves to maintain an identity that is compatible with the values of their profession. In addition to this we have seen that informants can avoid personal implication by citing reasons for these constructions as lying external to themselves. Analysis of the following extract (5) reveals further use of linguistic moves, which externalise the issues. In this extract the informant suggests that women in general readily accept caring as part of their identity, thereby implicating them as co-conspirators.

Extract (5)

Interviewer: In your experience do you feel that women are better carers than men?

Informant SCM1: Certainly most of the carers we get are women em. It's an impossible one to answer and hopefully I'm not being biased because I am a man em I don't know. I've had examples of both. I've had some male carers that have cared for mothers and their fathers and you couldn't better them. I would say what I said before it's women that seem to be, I don't know whether eager and willing are the right words but they seem to be, they tend to step into the caring role as opposed to men.

In a similar way to extracts (1) and (2) we see a response in extract (5), which evades a direct answer. The question, in its apparent directness, could threaten professional or personal identity. The response, "Certainly most carers we get are women", is more of a statement than an answer and clearly does not attend to the detail of the interviewer's question. Edwards and Potter (1992) see this as indicating that the informant has something to lose from providing a direct yes or no answer and so instead the informant engages in a linguistic manoeuvre, which avoids a negative attribution. We see further evidence of the management of stake in the form of hedging and avoidance with, "it's an impossible one to answer". Interestingly this stretch of talk also features what would appear to be an acknowledgement of the gendered hierarchy of caring (Waerness 1987; Qureshi & Walker 1988). We see this with the informant's reference to "male carers that

have cared for mothers and their fathers”, alluding to research findings that male caregivers rarely administer informal care to their mothers and fathers. Moreover the care provided was of a high quality, “you couldn’t better them”. Taken together these statements provide an example of extreme case formulation (Promerantz 1986). The speaker maximises the characterisation by suggesting that not only did they defy caregiving norms by caring for parents, their care was excellent.

The response taken as a whole is representative of particular representation, which was common to all of the informants, that is to remark on his personal involvement with highly successful male caregivers. This assists in building up a picture of the informants’ as having no axe to grind in that they are not predisposed to making gender assumptions. Moreover a regular pattern can be established whereby a statement of this kind has typically been followed by another, indicating that women caregivers have some quality that differentiates them from men.

A further important feature of the account is that it implicates women themselves in their own subjugation. Moreover they are described as being “eager”, enthusiastically impatient to be involved and as such the informant has no part in the process that women to this role. The fact that a greater number of women than men are involved in informal care is attributed to the products of the individual choices of women themselves. It is clear that this also serves to “psychologise” the issue. Notice also that the informant expresses the hope that he is “not being biased because I am a man”. Such a device is a

further example of Goffman's stake confession, that is flagging up an obvious point, which would not be missed by the listener (Goffman 1967).

Analysis of extract (5) demonstrated how caregiving is gendered as a result of women exercising the choice themselves. In the following extract of data we see how other resources can be brought in to provide a rationale for the female predominance in informal care. See the following extract:

Extract (6)

Interviewer: A lot of care is given by women, certainly according to the research. Now why do you think that is?

Informant DN3: Well for one thing women live longer so they're around to do it. I think the figures showed that for year one and year two, one third were men and two thirds were women.

Note also that the interviewer's question is worded differently to that of the previous extract (5). While the interviewer in extract (5) challenged the informant to offer an opinion with the use of a closed question, the question in extract (6) above is more open, soliciting the informant's perspective. Note how the emphasis changes to something less threatening with the interviewer setting up the question with a statement linked to research. In this response we see that the first resources to be drawn upon are statistical and demographic. The informant accounts for the prevalence of female informal caregivers as due to demographics and backs that up with statistical analysis of users of

the community nursing service in the location. Both of these resources provide a “scientific” reason for the gendered division of labour in informal care which can be a useful as a means of brings a neutrality to the interaction. The informant is offering a reason, which again lies outside her control. She is not reporting opinion, but fact. Facts provide ready resources, which can be mobilised to provide a rationale lying outside human influence.

The issue of whether service provides have a part to play in this issue is seen again in the following account in extract (7).

Extract (7)

Interviewer: Do you see yourself in any way as contributing to fixing women in that role?

Informant SCM 1: [pause] Possibly, possibly. I mean it tends to be when a referral comes in and the contact person. If that contact person is the female carer invariably that’s the person you liase with so I suppose yeah you do reinforce that role as carer.

We have seen in earlier sections that discourse is highly organized and follows regular principles. Extract (7) provides a useful example of the recurrent and routine features. Firstly the question and answer pair centre on whether the informant feels any personal responsibility for cementing women in the caregiving role. A pause precedes the answer indicating, according to Potter and Wetherell (1987) that a speaker is about to deliver a

dispreferred response mentioned in a previous section. In addition the answer is hedged with “possibly, possibly” and is not therefore an outright rebuttal or a firm acceptance. Again this is a common feature of dispreferred responses in that they are delivered rather weakly. It is worth pointing out that when answers are delivered immediately after the question has finished this usually indicates that a preferred response is about to be delivered. A further feature of dispreferred responses is that they tend to be supported as we have seen by an account, which attempts to justify the response. In this case the informant’s defensive move is to cite the process of referral to social work as binding women to caregiving and the reason for female involvement is put down to something akin to an administrative accident or a chance encounter. The informant’s final comments at the end of the stretch of talk is “I suppose yeah you do” and it is worth noting the use of the word “you”, citing not the informant himself but others in fixing women in the role of caregiver. The act is being projected as something that someone else would do, thus marking a change in footing which works to produce distance between the speaker and the act. Again the talk presents the problem as external to and not as a result of intent or premeditation on the part of the informant.

Research conducted by Lewis and Meredith (1988) and Twigg and Atkin (1994) discusses the reasons why individuals find themselves as the givers of care and one of the conclusions is that informal involvement often happens by stealth as the consequence of a pre-existing relationship. All of the informants cited the care of people with progressive and degenerative illnesses such as dementia as a major component of their role and as such it is clear that as the functional ability of the client declines then it

is likely to be paralleled with an increasing demand on the informal caregiver. In such cases the decision to become involved may rarely centre on a discrete episode where an active decision is made by an informal caregiver to offer support. In other words informal caregiving is more of a longer-term process, which involves a level of decision-making that is perhaps more reactive than proactive. The metaphor of the escalator is appropriate, in that once one has made the commitment to step on, it is then difficult to step off. In this process Lewis and Meredith suggest that issues concerning familial obligation, emotional attachment and altruism are at the heart of involvement and success and satisfaction in this role depends upon the quality of the relationship between the caregiver and the cared for (Orbel 1993). Given the analysis of extract (7) and the research by Lewis and Meredith it appears that a common form of accounting is to present involvement as something that occurs not by design, but by accident.

The appeal to accident was referred to by a number of informants and drew from a range of situations which could be categorised under that theme. See for example the following text (8):

Extract (8)

Interviewer: If someone has a female relative do you expect them to get involved?

Informant SCM 6: No, no no. If the offer of help is there you take it but you certainly don't say "right, whose doing such and such". Em the closest you get to that would be to have everybody sitting down in a case conference and say "right

well this is needing done, whose going to do it". I'd never phone someone and say "right you're gonna do the shopping" etc, etc, etc, unless maybe it was a crunch situation where you had no staff etc, and sometimes you get hit with illness, emergency situations where you say "oh we can't get anyone in this morning, would you possibly do this". It's very often a lady because they're the point of contact, not all the time but most of the time.

In this extract (8) the stretch of talk is organised again as question and answer and we see a direct request for information in the form of a closed question, "do *you* expect them to get involved"? In the light of previous analysis it is clear that this is a potentially threatening request in that it leaves little room for evasion. The response is a firm, immediate and anticipated rebuttal "no, no. no", The informant does not direct requests for support to individual women but to the group, as in a case conference. However there is also the assertion that in extreme cases when for example, unexpected events intervene, this may force a direct request to an informal caregiver. In this extract the informal caregiver is "very often a lady". The point is that this account again manages the problem of accountability by locating the problem or discriminatory act as existing or occurring without the informant having any direct influence over it. *Female caregivng in this instance does not happen as a wilful act but by accident.*

We see also the use of what Wooffitt (1992) terms "active voicing", whereby people produce accounts of events, which include sections of quoted speech. This is often marked quite subtly with only a change in intonation but in this case it is more explicitly

stated with “you say”. For Wooffitt active voicing is a frequently used linguistic device to build up factuality in accounts particularly in relation to talk about extraordinary events. We see that the events that would provoke a direct request to an informal caregiver are being cast as highly unusual and the informant is recounting the event and using the utterance, “oh we can’t get anyone in this morning, would you possibly do this”, as if it was said at the time. It is delivered merely as something that someone generally might say.

4.5 Personal experiences talk

Discussion thus far has focused on the stock of reasons, which can be drawn on to explain why more women than men are engaged in informal care. The reasons illustrated so far have centred on women’s intuition and instinct, demographic issues, service providers expectations and as a response to a calamitous situation. However personal experience can also be used to inform informants accounting. This is supported by Twigg and Atkin (1994) who found through interviews with a range of community care practitioners, that service providers regularly draw on their own experiences of family life. See the extracts (9) and (10):

Extract (9)

Interviewer: We talked earlier about gender and that more women are involved than men. Why do you think that is?

Informant DN1: I think it's just expected more of women than men, like this is a personal experience my husband's gran used to stay close by and she went off her legs. She just lived across the road and I was going across. Although she had people coming in I used to pop across at nine and put her on the toilet. I don't know whether he well he would have gone in and made her a cup of tea, did this or that for her whatever she would have done but as far as for taking her to the toilet was concerned, I don't think so. Em it was quite difficult for me and eventually his mum came down cos I was finding it quite a strain. I'd just had a baby but I felt as if it was my responsibility to take his granny to the toilet but I dare say if she was desperate he would have but again I think it's just a thing of, it's expected of women. We sort of expect ourselves as opposed to our partners to do it.

There are a number of issues to be drawn from the account in extract (9). Firstly we see that the informant describes a two dimensional pressure being exerted, implicating both women themselves in their own subordination as caregivers, and society as a whole. It is expected of women and women also envision it as their role as a response to internalised societal expectations. Women themselves are constructed as being uncomfortable with the idea of men in caring roles, seeing it as their own responsibility.

Secondly the informant strongly rejects the possibility of her husband assisting his grandmother to the toilet with "I don't think so!" Note that the explanation for this stance is not offered, presumably on the grounds that it is commonsense and therefore a given.

However it is interesting that cultural acceptability is used as a reference point. We see that just as it would be culturally unacceptable to offer assistance as a matter of course, it would be equally unacceptable to fail to act if a desperate need arose, hinting that an absolutist stance would be inappropriate. As pointed out in previous sections, men are the least likely to take an active role in informal care. Nevertheless the informant describes her husband as otherwise happy to engage in other activities such as providing a cup of tea or doing “this or that”, activities that would be considered acceptable or “normal” and within the bounds of a male gender identity. It is also worth noting that the account features another female and a more legitimate caregiver who was brought in to assist when things got too much.

As discussed in previous sections, an interesting topic for discourse analysts concerns the variability of and contradictions in accounts. Discourse analysts do not seek to reduce data to produce consistency but instead look to uncover the full range of accounting practices and so interviewers will often return to the same issue to check for a variation in response. For example, in extract (1) DN1 discussed the “female attributes” of “nurturing and caring”, accepting the proposition put forward by the interviewer that women are born with a natural ability to administer care. However in extract (9) her form of accounting changes to imply that women merely bow to societal pressures, “I think it’s just expected more of women than men”. Given the discussion on the possible influence that the nature of the question can exert, it is important therefore to consider the conditions under which the response was generated. We see that in extract (1) the informant responded to, “Do you think women are born with a natural ability”? In extract

(9) the informant is responding to a much more neutral and less threatening question, “We talked earlier about gender and that more women are involved than men. Why do you think that is”? The question generates less need for the informant to engage in protective manoeuvres as her projected self is not at issue.

We see further evidence of the use of personal experience as a reference point in extract (10) below.

Extract (10)

Interviewer: Research suggests that most caregivers are women. Would you say that was right? Why is that do you think?

Informant SCM5: Yes. Yes I would say so. It’s part of conditioning isn’t it. Em in my own family, my mum’s the one that’s had two strokes. She makes the tea and stands at the cooker. The carer as such, my dad, goes out every day to get his provisions and put his bet on and she stands at the cooker and won’t have it any other way. He’s a man and when he comes home at five o’clock she’s made the tea. He’s supposed to be the carer.

Again in this extract we see that the interviewer makes a request for the informant’s perspective but grounds the question in research as a means of making it less contestable. We see also that the answer is delivered firmly and with no delay indicating that this is a preferred response. The informant goes on to cite “conditioning” as an explanation for why most caregivers are women and supports this with an anecdote from his personal

experience. The informant's mother is regarded as being in need of care and this has placed his father in the position of caregiver. However the actual roles are less clear-cut in that his mother is described as still anxious to maintain her traditional obligations. In a sense she refuses to relinquish them with the effect that she is colluding in her subjugation.

As a further point we see ambiguity in relation to the informant's mother being the recipient of care but still *caring* for her husband and fulfilling her duties as a wife. This brings us to the etymology of "care" or "carer". It is acknowledged that the meanings of the above terms are ambiguous and this ambiguity is reflected in the account in extract (10) (Twigg and Atking 1994). The area of interest for us lies in the uncertain character of the caregiver and how the caregiver as a particular subject or identity has been produced. A starting point for the debate is Gubrium (1995 pg: 268) who asks, "what is this thing some call caregiving?" and although its implicit meaning is fairly obvious, authors such as Parker and Lawton (1994) have commented on the lack of a comprehensive model for understanding care. Green's model, for the General Household Survey took a task based approach and categorised care as providing personal care, physical help, help with paperwork and finances (Green 1988). Qureshi (1986) sees caring as practical tending and catering to social and emotional needs, while Arber and Ginn (1995) categorise it as physical labour, emotional labour and organisational/managerial labour.

We can see from this is that there is little in these definitions to allow discrimination between a carer and a non-carer. As the classes of activities mentioned above are performed in every household on a daily basis, the definition of what qualities denote a “caregiver” is far from clear. This leads us to question how the “carer” as a particular identity came into being. The obvious starting point is the work of Foucault who, although was not interested in language per se was concerned with discourse “as a system of representation” (Hall 1997 pg: 72). In other words, how particular objects were produced in language and brought into the world at particular historical periods. The introductory chapter discussed the historical context, which allowed informal care as an object to emerge. We saw that although informal care had been normative prior to the inception of regulated health services, the political ideologies of the 1980s allowed the re-visitation of the concept as an acknowledged and to some extent bureaucratised form of care. Although families engaged in a range of behaviours and activities associated with “care-work” such as those mentioned above, the actual concept of the informal carer did not exist as a distinct identity. It was brought into being by discourses or as Hall suggests “a group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment” (Hall 1997 pg: 72). The discourse in the 1980s on informal care as an object produced the informal caregiver as a subject. In the same way that the homosexual did not come into existence until medicine and psychiatry produced it as an object from medical, moral and legal discourses. As a result both object and subject can be discussed and quantified. Caregiving activities can be classified and models of informal care can be proposed.

The point of this is that the informal carer has been constituted as a particular person, with a particular character, engaging in a particular conduct, through drawing on the varied discourses that make up caregiving. In the same way that the homosexual did not come into existence until medicine and psychiatry produced it as an object from medical, moral and legal discourses. Now that the informal carer has been produced and is accepted it has become a familiar term to the extent that it operates transparently, is unquestioned and assumes the authority of “the truth”. While Foucault was not interested in discourse merely as language and his analysis does not work at the micro level, in extract (10) we see the way in which the informant’s father, described as the carer has been transformed into the subject. He has acquired the label “carer” and in so doing has been subjected to discourse. He is tied to that identity despite evidence from the account that his wife is also engaged in activities that could be classified as caregiving.

4.6 Caregiving as a class of gendered activities

The previous section considered how “personal experiences”, can be utilised in accounts to work up representations of the normative roles in caregiving. We have also seen how these accounts often locate the reasons for the gendered dimension in caregiving as external to the speaker. The following extracts provide further examples of resources that can be mobilised to explain women’s predominance. The following account illustrates how cultural assumptions can be brought in to create a version of social reality, which is contingent upon the perception of care as a generic skill.

Extract (12)

Interviewer: Now a lot of care is given by women, certainly according to research.

Now why do you think that is?

Informant DN3: Well there's one thing and that's that women live longer and we're actually around to do it. I think the figures showed for year one and year two that a third were men and so two thirds were women em it's a culture thing you know, that you cared for your children and you can care for your parents. It's like if it's a young girl left at home or if it's a girl left at home with two brothers, it's more expected by everybody that it'll be her that'll be the carer rather than the boys even though she could maybe have a better job than the boys and it makes more sense for the boys to be the carers.

We have seen this extract earlier but it is useful to focus at this point on how the informant cites culture as the underlying and independent explanation. At the same time the speaker refers to female caregiving as a generically applicable skill, and one that transfers to a range of situations and is learned through participation in childcare. For Chodorow (1978) and Graham (1983) the essence of the feminine role hinges on that of child carer and nurturer. This role is clearly being presented as one that can be generically applied, creating no potential for ambiguity in the way that male care would. It is interesting to note that the growing role of men in childcare is not drawn upon. This suggests that despite their increasing involvement in the care and nurture of their children, childcare by women or mothers is constructed as the legitimate form in that it is biologically directed. Men therefore do not have generically applicable caring skills.

However the argument put forward by the informant loses its consistency as other ideas are offered further into the stretch of talk. The informant cites an imaginary situation whereby a young girl left would be drawn in to caregiving. Clearly a young girl would not have had the experience of being a mother and would not therefore have the childcare skills, so perhaps the informant is alluding to an innate predisposition towards the care of children. The informant, in common with other extracts sets the theme from the outset within the context of cultural norms and again refers to pressures or forces that are situated *out there*. In arguing that “it’s a culture thing” and is “expected by everybody”, the informant is putting distance between herself and the ideas expressed in an attempt to create the impression of neutrality. Note also the use of the word “everybody”. It would not just be expectation of the informant but would be a global judgement. It is also worth commenting that the practicalities of earning potential are also referred to with, “it’ll be her that’ll be the carer rather than the boys even though she could maybe have a better job than the boys and it makes more sense for the boys to be the carers”. Who performs the caregiving is clearly significant in terms of an economic rational. However, having the “better job” does not mitigate against involvement.

It is evident from literature reviewed in earlier sections that there are financial implications in caregiving and an important issue remains the restrictions that involvement in informal care places on individuals in terms of access to paid work. This has to some extent been recognised by the *Carers, Recognition of Services Act* (1995), which created entitlement to a means tested allowance for those heavily involved in

caregiving. However it is clear that in the informant's account, gender assumptions are portrayed as overriding any "commonsense" practical economic considerations.

So we see from the extracts analysed so far that informal care is gendered in talk with reference to a conventional stock of resources that can be mobilised to account for female involvement in caregiving. From the informants' accounts this occurs as a result of a number of forces, which relate to either a natural or a social order. Analysis of the following extract reveals how female caregiving is presented as stemming from an outmoded social order but nevertheless cites the generic skill theme as the force underpinning the tradition.

Extract (13)

Interviewer: What do you think about the research that's been done on the gender aspect of care, the fact that more women than men are involved with informal care? Why do you think that is?

Informant DN2: I think it's because women are involved in families nurturing and caring. They've always been the providers of care. The males have been the breadwinners.

Interviewer: Is that a common conception? Is it valid?

Informant DN2: Well I think for the generation we're dealing with I think they can have these notions. It's what they've grown up with and what they've lived with but whether it's valid or not I don't really know. A great deal of carers are men.

Interviewer: Do you think that women are necessarily better at caring than men?

Informant DN 2: I don't think so, no. I'm just thinking of an couple, he's not on our case load but he's really and another one. Their wives have had strokes. One in particular, he's very caring so I don't think it's necessarily women that make better carers but they have certain qualities which enable them to care intuitively.

Again we see that the resource drawn on in this extract relates to female identity as finding its expression in the “nurturing and caring” within families. The informant is places this within a historical context with, “They’ve always been the providers of care”. At the same time men and women are set as dichotomous, men being “the breadwinner”, women “the providers of care”. In the introductory section of this chapter it was commented that women and men are commonly set in opposition to each other, as a “single bi-polar dimension, a unitary continuum” and we see form evidence of this in this account (Hare-Mustin and Marecek 1994 pg: 61). The interviewer responds with, “Is that a common conception? Is it valid”?, which is unmistakably oriented towards establishing the interviewee’s perspective on the proposition. Note that the informant puts distance between herself and the view by attributing it to another generation, saying “they can have these notions” and hedges that she does not “really know” whether it’s valid or not. For Potter this is a familiar form of externalising device which serves the purpose of presenting the description as not one that the informant would necessarily subscribe to. The response is orientated to the idea that the stereotypical description of sex roles is outdated and therefore attributes it to an older generation. However this description is contradicted at a later stage in the extract as the informant cites that female intuition

enables women to care. Wetherell et al (1987) refer to this kind of account as “unequal egalitarianism” in that speakers may espouse sentiments, which can be viewed as supporting apparently liberal ideals, but as a contrast draw from competing accounts that support patriarchal privilege. The informant in extract (13) in implying that classified sex roles are synonymous with outmoded ideas is tapping into an anti-discriminatory repertoire but this is effectively neutralised with the assertion that women are naturally inclined towards caregiving.

The informant in the following extended extract (14) has been discussing the pressure put on informal carers and brings to mind a recent event. A male patient has been discharged from hospital following major bowel surgery. He has arrived home with a leaking wound and a new stoma that will require intensive maintenance over the coming weeks. The patient will need to be proficient with the technical aspects of changing a stoma bag and become accustomed to his altered body image. He is reluctant to have an unfamiliar nurse visit over the weekend and has suggested that his wife attend to his dressing and stoma although she has not had any experience of either procedure.

Extract (14)

Interviewer: Do you think there's pressure on informal carers to be actively involved at home because of the forces to get patients out of hospital and into the community?

Informant DN3: Do I think there's pressure on carers? Definitely. It's difficult because sometimes the patient only has to hear. Like this new man we've got

today. The patient has to hear, “you might get home at the end of the week” and they’ve got their bags packed, maybe a few days too early. I mean this man’s come home, he’s got a huge leaking wound. He’s got a brand new stoma which obviously he’s still coming to terms with. He’s got eight children, a dog, a wife and a really busy house. The decorators are in and I’m thinking another few days would have made all the difference. He hasn’t seen the stoma nurse, she’s coming next week. I showered him today and tried to give him some support. I’m coming back tomorrow. It’s a long time. He’s come home too early. Another few days. And he can hardly walk and it’s “F get me this, F get me that” and she’s got eight kids, a house and a dog and now a sick husband as well.

Interviewer: Does she feel under pressure?

Informant DN3: She was on the phone while I was in and all the kids were making demands so I didn’t actually speak to her today. Hopefully I’ll catch her tomorrow. And he doesn’t want a strange nurse visiting at the weekend so he said “F will do the wound” so I said “how does F feel about doing the wound” and I said “what if the bag comes loose as it did today cos’ it’s new and takes a while to settle down”. So he shouted her through and I said “what about doing his wound” and she said, “well I’ve had eight kids, I’ll do his wound”.

In this long extract the informant provides an extensive narrative as a response to the interviewer’s question regarding whether informal caregivers are burdened as a result of a shortage of hospital beds. A number of important areas of interest for the discourse analyst can be noted from this stretch of talk. Firstly it is evident that the informant’s first

response is to repeat in a summarised form, the interviewer's question. This is followed with the agreement "definitely" and then a move to substantiate her vehement response with an account justifying her reasons. However, despite agreeing that informal caregivers are put under pressure, the informant cites the reasons for this as lying, not with bed shortages, as the interviewer suggested, but from patients themselves. This account describes patients as being overly keen to return home at the earliest opportunity, even when early discharge might compromise a full recovery. Indeed it is the discharge of patients still requiring medical treatment that is a significant contributory factor in caregiver burden and this is highlighted in the account, emphasising the nature of the patient's medical and nursing needs.

We see that he is described as having a "huge leaking wound" and a "brand new stoma". As referred to in earlier sections, Promerantz (1986) suggested that individuals frequently draw on extreme cases to emphasise a point. Having a "huge leaking wound" and a "brand new stoma" work successfully to maximise the description of the surgical and nursing needs of the recipient of care. Furthermore we see references to possible psychosocial complications resulting from early discharge as the patient is "still coming to terms" with his altered body image. Indeed he has not yet seen the stoma nurse, who could validate his new identity and without which, his psychological adjustment could be delayed. With the use of this formulation the informant strengthens her point, which is that patients themselves in their keenness to get home, burden informal caregivers.

The narrative style is put to rhetorical use as a means of building a picture of a “busy house”, with specifics such as the eight children, the dog and the decorators. From these details we are able to visualise the extent of the burden that has been imposed on this caregiver. In addition the informant points out as a means of emphasising her professional responsibility and concern, that in her interactions with the recipient of care she herself “tried to give him some support”. As a response to the narrative, clarification is sought as a means of uncovering how the caregiver felt. It is interesting to note that rather than merely admit to not knowing whether the informal caregiver actually does feel “under pressure”, the informant responds by mounting an immediate defence by saying “She was on the phone while I was in and all the kids were making demands so I didn’t actually speak to her today”. By bringing in details such as being engaged in a telephone conversation and children making demands, the informant is emphasising the constraints on any interaction between herself and the carer. Therefore, rather than respond with a “no” and create the potential to be evaluated negatively as neglectful, the informant responds with an excuse or justification, which serves to maintain a positive professional identity.

In relation to the construction of gender, there is also an implicit acceptance here that childbirth and childcare are experiences that qualify the woman in this account for involvement in the nursing procedures required by her husband. Nursing and childcare are constructed in this extract as one and the same. The caregiver offers up childbirth as prior experience and this is accepted as valid by the informant. The account is organised to give an impression of a consensus regarding its “naturalness” and it is implied that the

informant, the caregiver and the recipient of care find this unproblematic. The commonsense reasoning in this account constructs women as natural carers by virtue of their biology. Oliver (1983 pg.76) comments that all too often

the presence of a wife in the home means that a man will be discharged earlier from hospital, receive fewer aids and adaptations in his home (his wife can answer the door/ cook his meals/ assist him to the upstairs lavatory)....

Certainly it is accepted that any recipient of hospital care would be keen to return to their home environment rather than remain in hospital. However this extract provides a pertinent example of Oliver's concern, which is the assumption that if a client is returning home into the care of a woman, then their nursing needs will be met. This extract is representative of the findings of *"You can take him home now" – Carers experiences of hospital discharge* (Holzhausen 2001), which highlighted the issues faced by informal caregivers in relation to early hospital discharge. The study found that informal caregivers commonly reported feeling that they had had their contribution taken for granted to the extent that they were not consulted about the discharge of the patient. Further that patients were discharged before they were well enough.

The construction of care as an activity related to childcare is a central aspect of the cultural understanding of caregiving and was frequently cited within this context. Here we see a recurrence of the theme of changing times and changing roles in extract (15).

Extract (15)

Informant SCM2: Maybe if it comes to transport or something that's fine, they'll get in the care and drive from A to B maybe do shopping or maybe sit with them for the afternoon.

Interviewer: But not much involvement in personal care?

Informant SCM 2: No I can't think of any male carer that's been involved with personal care.

Interviewer: Where does that come from?

Informant SCM 2: I think it's probably historical. I think probably in twenty years time it might be different. There are more men now compared to twenty years ago who have taken an active role in children, changing nappies, pushing prams, that wasn't done thirty or forty years ago and I think in another twenty years we'll see more of that.

It is interesting to note that the focus of this interaction was on the relatively few men that will readily provide physical or personal care in social relationships. In the informant's experience, she has not known men to be engaged at this level. They will readily engage in driving the recipient of care to hospital appointments or shopping and "sit with them for the afternoon" but they will not be involved with the "hands-on" delivery of care. Once again we see how traditional roles are being undermined as more men become involved with the practical aspects of childcare. However we also see informal care constructed as an aspect of childcare. As more men become involved in the care of their children then a gradual process will occur whereby men emerge as informal caregivers

who, rather than have merely a driving or befriending role, will be willing to deliver personal care. The point is that as Oakley (1974) commented, housework and child rearing are seen as women's work. Indeed the two roles are often poorly differentiated. Therefore we see that as informal care is linked to childcare and as childcare and domestic labour are increasingly performed by men, the idea is that informal care will be assimilated into the masculine role.

Just as caregiving is constructed as involving skills learned through childcare, failure to differentiate between motherhood, domestic labour and caring is evident in the following extract (16):

Extract (16)

Interviewer: So you think its part of a woman's nature?

Informant DN6: I think so yeah?

Interviewer: Why is that do you think? Are women born that way or?

Informant DN6: I suppose, I would imagine yeah. Women are in a role to be a mother, to care and that just goes on. A mother, I mean a woman cares for all sorts of others, cares for the home, cares for people, cares for her family, her children.

Considering first the organisation of this extract we can see that the interviewer produces a question about whether caregiving is part of a woman's nature. The informant responses are less certain than those offered in other examples of text. We see the use of

terms such as “I think so”, “I suppose” and “I would imagine” which give an impression of uncertainty, as if this is the first time that the informant had considered these issues. Again Goffman (1967) considers terms such as these as “hedging” or qualifiers as they are put to use to try to create a distance between the informant and the potentially obnoxious view. Hedges also demonstrate that the speaker has anticipated that the response may be received badly by the questioner, creating the possibility that their professional identity will be discredited. For Goffman the informant is “suppressing any show of feeling until he has found out what kind of line the others will be ready to support for him” (Jaworski and Coupland 1999 pg.310).

Turning to the themes within the extract, we see that that account offered by the informant concerns women’s nature. That women are predestined to become mothers and caregiving is just an extension of the mother role. Caregiving as at the core of that role and the informant cites a list of examples to illustrate the point, that a mother cares for “all sorts of others, cares for the home, cares for people, cares for her family, her children”. The use of lists is an important and common device, according to Jefferson (1990) and is used to demonstrate the generality of an object or situation. In this case the list has been produced to emphasise how broad and indeed how commonplace the care delivered by mothers is.

For Oakley (1974) nursing is essentially paid domestic labour in that the skills used are those learned during “the long apprenticeship” that women undergo as homemakers. She argues that most of nursing involves a replication of what happens in the home, that

is physical and emotional labour. The following stretch of talk is part of a longer extract. The informant has been talking about an example of unsatisfactory care and is asked to provide an example of the other extreme. The informant responds by discussing in some depth the extensive proficiencies of this informal caregiver but our interest at this stage of analysis relates to the notion of good care as an aspect of domestic efficiency.

Extract (17)

Interviewer: You must see carers where you would consider it to be good care.

Informant DN 1: There was one. A patient just died there. He was a man with oesophageal cancer. He had a tracheostomy. He had a peg tube. You know he was terminal really for quite a while although latterly he'd really, really went down and his wife was excellent with him, you know, em, she hated the nurses helping him. Em you know she used to sort of help him to wash and you know put his uridome on, put his uridome off, connected up his food, em you know, put the medication down his peg tube, you know. She would change the trachistomy tube, you know if it got blocked she knew how to change it, em, you know she was like did everything really that he needed around him. She slept in the same room in the bed next to him and you know was concerned about his skin. I mean she as excellent, she really, really was. You could tell you know, just going into the house you could just tell that you know she cared for him

The initial response to the question of good care centres on practical examples which are selected to justify this as an exemplar of good care. We see reference to a number of quasi medical procedures, issues that will be discussed in a later section. However what is interesting at this stage is the informant's description of entering the house and getting an instant impression of a successful caregiver at work. What is this suggesting? The picture built up in this short extract conveys a sense that the caregiver kept a clean and comfortable house and perhaps for the informant, good care is representative of the successful management of household tasks. The account of caring which implies that to be a good carer is necessarily to be a "good woman" is entirely familiar to feminist discourse. Women predominate in the division of labour within the domestic sphere and are defined to a large extent on their ability to service their families, particularly in relation to cooking and cleaning. The informant could tell that the patient was receiving good familial care because the domestic sphere appeared to be in order and therefore well serviced.

The perspective offered by authors such as Oakley (1974) is that housework is ideologically women's domain and is a role by which women can attain some degree of satisfaction. As domestic labour is pivotal to family life, Oakley argues that women's feminine self-concept is deeply rooted within housework. There is also a tendency for women to orientate to the role of housewife within the context of a view of masculine and feminine gender roles. We see such an orientation described within the following extract (18):

Extract (18)

Interviewer: Do you have any specific examples of informal caregivers that you have been involved with?

Informant SCM 2: I'm thinking of one man in particular who lives alone whose mother and father are quite elderly who were very concerned about him and his care but they couldn't accommodate in their own home partly because of his very difficult behaviour. He was a chaotic drug user. He was someone who could be very aggressive verbally in particular. He needed quite intensive input and we had what we call a network meeting and we invite the person themselves, any immediate carers and any agencies that would be able to supplement that care to that meeting. We focus on the person on what they might want to say. It's very much focused on their needs. We look also at what the carer feels comfortable with providing. Now in this man's case his mother particularly wanted to do some of the domestic things in the household. Something she could do that he would accept and would make her feel that she had a purposeful role and it also meant that she didn't have to assume any responsibility for a full-time caring role because he found that very difficult particularly at this stage as he required personal care, bathing and dressing. That was in the main provided by the social care officers and occasionally by the community nurse and from the multi-disciplinary team and I mean it was a pretty extensive care package.

One of the major concerns of the discourse analyst is to examine what discourse does. How it functions to counter other versions of events and the extract above, like all accounts is itself a version of an event to which there may be alternatives. Looking at the extract we see that the informant is responding to the interviewer with an extended or narrative example of family that she been recently involved with. The narrative is structured essentially as an evaluative account, whereby the informal caregivers are presented in a favourable light. Throughout the extract the informant is working up a representation of particular informal caregivers who are attentive despite limited involvement in “hands-on” care. This presents as something of a problem for the informant in terms how this version of events is received. Therefore the narrative has to be designed to counter the possibility that the actions of the informal carers are received as neglectful and uncaring. Looking closely at the text we see that the informant has selected a number of pieces of information that portray the nature of the individuals involved. From the point of view of Sacks (1972) if people are portrayed in particular ways then we are able to make a good guess at the kinds of activities that they will be engaged in by drawing upon our conventional stock of knowledge. Considering the information we have been presented with, we see that the mother and father are elderly. From Sacks’s perspective we can infer from this that caring for a son who is a chaotic drug user and who displays difficult behaviours and is verbally aggressive would be problematic for the informal caregivers. These activities would not meet with the normal role that elderly informal care givers could be expected to engage in. Therefore the informant has justified their limited involvement and has successfully brought off a

representation of them as caring and as such these points are central to bringing off a successful representation.

From this we see informant's description of a situation where the client's mother was orientated towards housework as a means of maintaining an active and valid role. There is a clear indication that the individual wanted to be involved in caregiving at some level and wished to tend the client. There is a suggestion that both mother and son felt it inappropriate to administer personal care. Such an orientation implies that housework is considered "safe territory", a favoured option to allow the demonstration of affection.

4.7 Theories talk

As we have seen from the analysis so far, a number of perspectives have been offered to account for the gendered division of labour in caregiving. The informants' have offered their accounts to explain this. Similarly in the following extract the informant is asked about her views on why more women are involved in informal caregiving and offers a range of theories for why this might be the case. The interaction commences with a statement concerning a point made earlier by the informant. The informant responds with ' "oh on average I would say". Schiffin (in Jaworski and Coupland 1999) has provided a useful discussion on the use of *Oh*. Schiffin points out that *Oh* occurs in talk when speakers shift their orientation to information, marking that its producer has undergone a change in his or her state of knowledge or awareness. *Oh* is used in a variety

of conversational contexts such as repairs and acknowledgements. It is also frequently used with answers as we shall see in the following extract (20).

Extract (19)

Interviewer: You've mentioned that a lot of carers are female.

Informant DN4: Oh on average I would say.

Interviewer: Obviously the research backs that up. Men are becoming involved but still its predominantly. Why do you think that is?

Informant DN4: Well there's several theories. Could be a gender thing a child, a wee girl with a doll, she's the mother, she cleans etc, etc, etc. Also because she's seen to be earning less so if there's a wage gonna be lost. The parents, be it mother or father. Their attitude, their values. I don't, I don't want to be putting words into patients' mouths. I understand that there's a lot of different reasons. Guilt, guilt. Males and females are meant to do. Men, I think it's changing. I don't know.

According to Schiffin answers to questions are prefaced with *Oh* when the questioner has wrongly assumed that the information given in the question is shared by both parties. Put simply *Oh* makes explicit to the questioner that they have assumed too much.

Considering the informant's response then we can see that oh has been used within this context to make explicit that the interviewer made assumptions about comments made earlier. The interviewer had assumed more shared information than the informant thought warranted, hence the response "oh, on average". The interviewer's statement was

delivered as an utterance, “You’ve mentioned that a lot of carers are female” and it is clear that from the response it has been received as potentially damaging to the informant. The informant’s response is therefore orientated, not to a denial but to a limitation of the statement in order to ward off the possibility that it may be attributed as something suggestive of discrimination or bias. With the utterance “on average” the informant has anticipated that it may be attributed in this way and instead attempts to relate her comments to a *general* observation she has made. The next move by the interviewer is orientated towards repairing the violation by referring to research, which serves to factualize the statement, therefore making it an objective reality and not the subjective and biased view of the informant.

The informant continues in this vein by rather than be drawn on her personal ideology she presents a variety of “theories” as explanation such as socialisation, practical considerations, other people’s values, biological imperatives and emotional reasons. The informant has presented a number of diverse possibilities, which are not unusual and are fairly representative of debate in this area. However, the informant is clearly careful to produce *theories* rather than discuss her personal ideas and as such is seen to retreat to impersonal territory. The response, “well there’s several theories” functions in a similar way to the phrase *it is thought that*. For Potter (1997) one way to produce an account as impersonal is to base it on the views of others and therefore avoid identification with one or another of the ideas. In other words, to locate the problem “out there” and therefore, separate to the speaker. This way the informant avoids being drawn into any potentially damaging situations where she may be implicated as holding *discriminatory* beliefs. The

extract ends with, “I think it’s changing. I don’t know”, implying that the state of affairs is unacceptable therefore adding further distance between the informant and her utterances.

4.8 The construction of the deviant female identity

The ethos of the familial model of care, according to Dalley (1988) is founded upon the notion of the bourgeois family with its ideals of marriage and the cultivation of a domestic haven for the husband/father and children. Berger and Berger (1983) summarise the virtues of ideal family thus

An emphasis on high moral standards, especially in sexual matters; an enormous interest in the welfare of children, especially proper education, the circulation of values and attitudes conducive to economic success as well as civic peace; at least the appearance of religious faith; a devotion to the “finer things” in life, especially the arts; and last but not least, a sense of obligation to redress or alleviate conditions perceived as morally offensive. (Berger and Berger 1983 pg. 7)

Berger and Berger highlight the popular construction of the family as that of a well-defined domestic unit providing an environment, which facilitates the care and constraint of its members. They argue that over time the values espoused by the bourgeois family, such as those above have come to be regarded as an ideal. They

suggest that principles on which the bourgeois family has been founded have colonised modern western society, spawning a range of professionals who now police the working class in the name of those values. Such professionals according to Dalley are informed by “experts” such as Bowlby (1953) and Leach (1979) who favour the traditional patriarchal model of the family with the father as breadwinner and mother as service provider for husband and children. Walkerdine & Lucey (1989) suggest the term “Bowlbyism” to describe the force, which has propelled the regulation of nurturing practices. Having introduced the “institution” of parenting, expert opinion has for DiQuinzio (1999 pg 215) “superimposed” a set of attributes, which are used to determine the nature and quality of parenting.

Therefore the very value of the parent resides in their ability to meet the needs of their dependents and clearly this draws from cultural notions of masculinity and femininity. This means that parents or more particularly, women who fail to live up to the predetermined bourgeois standard are depicted as reneging on nurturing practices and have by implication, failed to fulfill the essence of their “natural” gender identity.

The cultural representation of the feminine identity as caregiver and nurturer lie at the heart of discourse on gender and draw from the relationships between caring and mothering. The following extract (20) provides a pertinent example of this relationship.

Extract (20)

Interviewer: Do you see any examples where you've been involved with bad care? Can you think of any examples?

Informant DN 1: Em some years ago in Glasgow where we worked there was a lady, again with dementia and the house was pretty bad, in fact it was disgusting, and em the daughter who looked after this lady just sort of left her in this bed and em didn't feed her properly and she was eating incontinence pads and stuff and there was incontinence pads everywhere you know, they didn't make sure there was adequate bedding and to me you know that was bad care. Yeah there was this lady and the house was just awful and the social workers were involved as far as the children were concerned, well the children were of school age but you know, of the daughters and they never went to school, sort of like "well my mother never got me up on time", kind of thing.

In the above extract we can see that the informant gives a version of bad care which uses mothering as a cultural resource to characterise the essence of caring. She makes the points that "the house was just awful" and that "the social workers were involved as far as the children were concerned". The individual cited is depicted as having a disregard for basic household tasks and domestic hygiene. Moreover she shows no obligation to the proper education and welfare of her children. In essence we are presented with a woman who has not met her responsibilities as a mother and therefore by implication, cannot be a good carer. The theme is taken forward thus in extract (21):

Extract (21)

Informant DN 1: I don't think they starved her deliberately, but I mean they just didn't feed her properly

Interviewer: They just weren't responsive to her needs.

Informant DN 1: Yeah, yeah and they were just you know they weren't really capable of looking after an elderly demented lady, who just sat where you put her you know, she didn't sort of get out and wander about she just sat and the room was very poor and I mean I don't think they were very responsible parents. It was just a shame really. It was just horrible to go in and see them. That lady eventually got taken back into care. It really can't, cant' go on.

In this extract (21) the individual is again characterised as being irresponsible. However the father makes an appearance at the end of the utterance when the informant refers to "parents" in the plural. This serves the purpose of producing a picture of a failed family. Both mother and father have failed to meet their parental obligations, which again melds with the caring as a generic skill resource mentioned in a previous section. Oakley's study of housewives and domestic labour concluded that "In only a small number of marriages is the husband notably domesticated, even when this happens, a fundamental separation remains: home and children are the woman's primary responsibility" (Oakley 1974 pg. 164). Therefore the family's failure to meet their obligations can be laid at the feet of the woman.

Furthermore, dementia is typically characterised as an illness, which brings the potential for significant levels of carer stress and burden (Zarit and Edwards 1996). However the informant cuts off the possibility that the family may have been unable to cope with the patient due to caregiver burden associated with caring for an individual with difficult behaviours. The informant's utterance of "who just sat where you put her you know, she didn't sort of get out and wander" wards off the potential to attribute the unacceptable care to anything other than fecklessness. In presenting the patient as compliant and docile the informant's account is orientated towards persuading the listener that that the version of bad care presented, is exactly that.

The theme of the failed family is evident in the following extract (22). The social care manager is providing an example of bad care and remembers a client with dementia who was looked after by his three daughters.

Extract (22)

Interviewer: Can you think of any examples of where you've been less than happy with the standard of care given?

Informant SCM1: Yeah. Two daughters had various problems with drugs and alcohol and were basically ripping this guy off and it was ridiculous and it wasn't just that he was badly clothed he was left without food. I mean the little that they did spend on food for him if they'd gone out drinking they would stop by his house and leave him with nothing. The neighbours would come and say, "this guy's got absolutely no food, there's no heating on", so we'd have to get

him food parcels to tied him over to the next pension day which obviously.... I mean they classed themselves as carers and they actually tried to get carers allowance as well which was stopped. Eventually we managed to get the pension book back from them at which point the situation got really nasty. The client actually had to move to another area because they would actually turn up at the house and threaten him because well they'd seen him as being responsible for taking away a source of their income. Initially they were classed as carers as they were the initial contact from the social work department but basically they were caring to the point that he was left without heat or food in the house.

The above extract (22) again offers a version of bad care set within the context of the failed or dysfunctional family. Bad care is articulated with reference to family members who apparently conceive of themselves as carers but do not fulfil their obligations in terms of meeting basic needs. In contrast to the family in extract (21) who were presented as feckless, the family in extract (22) are presented as people who willfully exploit a dependent relative for personal and financial gain and threaten violence when thwarted.

A consistent emphasis in the accounts of caring centred on the meeting of physical and medical needs. However with the utterance, "initially they were *classed* as carers", it is clear that a further resource is being drawn on in the evaluation. The focus on this piece of text hints at a technical or legal classification of carer, which is used perhaps to judge eligibility for benefits such as a Carers Allowance. So we see the dual construction of

caring which is fundamentally relationship based but at the same time technical and bureaucratised. Furthermore it is clear from the following extract (23), part of the same account as extract (22) that if the carers are not seen to be acting out their familial obligations then they can be penalised by ceasing access to benefits.

Extract (23)

Informant SCM1: It's the only one I've come across where they have actually left relatives without food or heat but quite often it's the in between ones that are maybe more difficult em because you have to go in and start taking benefits away from carers. First of all you need good evidence to know that the harm they are doing the person.

As Ungerson (2002) highlights, the increasing visibility of informal caregivers has facilitated political leverage in terms of *acquiring recognition for services* supplied by carers. As many caregivers cannot access a working wage due to caring commitments some meet the criteria for means tested compensation. Although recognising the value in this, Ungerson proposes that the cash exchange for services rendered causes a dilemma in that it *commodifies* what is in most cases, a social relationship. The dilemma lies in the potential to affect the relationship between the caregiver and the care recipient and indeed the caregiver and the state. It is clear from this extract (23) that such fears are not without foundation in that the Carers Allowance perhaps changes the emphasis from *care* to *work*. Caregiving from the perspective of Graham (1984 pg. 16) has a dual nature, “as labour and as love” but perhaps the commodification of care

diminishes the symbolic nature of caring. The caregivers referred to in this section of text apparently failed to meet the demands associated with their role, demands which in themselves had been shaped by the dual demands of society and the state.

4.9 Chapter Conclusion

The beginning of this chapter introduced the various approaches to examining gender. It focused on the notion of an essential and enduring female and male identity, which is born either from the socialisation of infants, the formation of identity at critical periods and the effects of biology. However it was proposed that feminine and masculine identities, rather than being fixed states are in “reality” social practices. From this perspective gender identities are constructed through the ways that society and individuals speak about them. At the same time certain social practices and forms of behaviour become associated with a masculine or feminine identity.

This chapter focused on a number of points. Firstly the data demonstrated that the examination of attitudes and beliefs on the topic of informal care and particularly gender is far from straight forward. Both sets of informants drew from a range of competing ideas on gender, evidencing the competing ideas within the conventional stock of knowledge. For example the informants’ talk concerned the notion of female caring qualities such as intuition and a caring instinct. In addition the informants also drew from ideas concerning equality and anti-discriminatory practice. The contradictions within the discourse cannot be missed and it is clear where the difficulties would lie in attempting to

locate a particular attitude to the informants, were a realistic perspective taken with the data. Certainly the informants' talk could be traced back to the prevailing propositions that have been made regarding the nature of the male and female "disposition", but it was also influenced by other ideologies such as the principles of equality.

Moreover the analysis demonstrated that informants are alert both to the contradictions in their statements and the potential damage that these statements may cause to their personal and professional identity. For this reason we saw the deployment of a number of techniques concerning stake inoculation and confession as a means of avoiding the possibility of being discredited, and externalising devices to present accounts as neutral or the views of others. In addition the analysis revealed the techniques used to achieve the objective of fact construction in narrative accounts.

In conclusion, accounts construct the female delivery of informal care as normative in light of an enduring female identity. We see that the narratives, anecdotes and "opinions" offered by the informants express caregiving in its "correct" form as female and that it is woman's natural biological state in reproduction together with child rearing practices that provide the rationale. Caregiving in this construction, thus becomes a fact of nature and is bound up to nurturing and domestic practices, hence the linkage between childcare, housework and nursing. Further the analysis demonstrated how the informants' evaluations can be read as judgement on women's moral identity through an apparent lack of orientation to, or success in those practices. As informal care is expressed as a moral obligation, failure to fulfil the obligation brings a negative moral assessment.

Furthermore the accounts describe the complicity of women in their subjugation, that women are orientated to caregiving as a set of social practices that they feel comfortable with. Women therefore “do” gender by engaging in caregiving practices and meeting obligations because these practices are what it means to be female. As there are no cultural taboos, which render informal care by women inappropriate, inappropriateness is thus measured by moral dimensions. Therefore women who do not “do” gender in the socially prescribed way risk being constructed as deviant. Throughout the accounts the identity of the caregiver is of prime importance in the division of caring labour. Although many of the informants refer to the apparently increasing numbers of men involved in informal care, caring remains the preserve of women. This supports the concept of the hierarchy of care in, which male informal care is defined as the least preferred.

Chapter Five

Male identity

5.0 Introduction

The previous chapter demonstrated how caregiving can be constructed as a natural element of the female identity. Chapter five builds on this theme by pointing to data which constructs informal caregiving as lying outside the true nature of male identity, a way of being that militates against involvement in intimate and personal care. The analysis again utilises examples of text to demonstrate how “commonsense” on informal care is formed from a range of ideological resources, with some obvious contradictions. As in the previous chapter the analysis also focuses on linguistic techniques such as the management of stake and the use of narratives to present accounts as a *truthful* interpretation of events.

5.1 Conventional perspectives on the male gendered identity

Although the burden of care has traditionally fallen to women, male caregivers constitute an increasingly recognised group (Bowers 1999). However this growth is to be found predominantly within married couples, the partner assuming tasks that have previously been performed by the partner who is ill or disabled.

The view of male and female as opposite and therefore mutually exclusive has a long-standing association with western tradition as detailed earlier. We see that throughout history men have been regarded as task oriented and better suited to public and work life. While women are aligned to nature, men are associated with reason and technology. Masculinity and femininity have been culturally defined in terms of each other, “what one is, the other is not” (Hare-Mustin & Marecek 1984 pg.61). However work of authors such as Eagly and Crowley 1986 and Eagly and Steffen 1986 (cited in Hare-Mustin & Maracek 1994) point to the variation in so called male and female behaviours such as helping and aggression depending upon the social expectations within the setting,

For example Greenhalgh, Vanhanen and Kyngas (1998) conducted a study using questionnaires identifying the caring behaviours of nurses. Nurses were asked to rank a range of caring behaviours according to importance. The authors concluded that male nurses were less likely than female nurses to be accessible or form fewer trusting relationships than their female counterparts. Male nurses were said to value fewer caring behaviour, suggesting that there is a gender dimension to caregiving. However this study demonstrates a number of flaws in attitudinal research. Firstly, in line with Eagly and Crowley and Eagly and Steffen cited above, the importance of helping or caring behaviours, are dependent upon the expectations of the setting. Secondly as Potter and Wetherell (1987) comment, when people are making a judgement about an specific “object of thought” in this case caring behaviours, it relies on a consistent shared understanding of terms used by the researchers such as “comforts” or “trusts”.

Furthermore to what extent can we expect consistency over time? Will the categories of caring behaviours be ranked in the same way on other occasions?

But of course what constitutes caring behaviours and indeed masculine and feminine behaviour is itself constructed through language, a medium that is influenced by historical, cultural and political imperatives. Therefore there is no single “truth” regarding the meaning of “typical” male and female behaviour, only versions which themselves reflect how the social context has shaped knowledge and meaning-making. Interestingly Rorty (1979) comments, “the notion of accurate representation is a compliment we pay to those beliefs that are successful in helping us do what we want to do” (cited in Hare-Mustin & Maracek 1994 pg: 52). Representations then, serve a purpose in that they allow the ordering of social life to the extent that the knowledge embedded within them becomes commonsense and thus proper.

The perspective offered by Edley (2000) supports this with the idea that gender is something that is accomplished through the performance of activities that are understood as normative forms of gender specific behaviour. So masculine and feminine identities are things that are worked at as a consequence of what is known about what it means to be masculine or feminine. Society imposes restrictions on what it will accept as masculine on the basis of this commonsense understanding. Of course individuals are not obliged to conform to these expectations but there can be several disadvantages in a failure to perform gender specific behaviour, as highlighted by the discussion on deviancy in the previous chapter.

Edley also suggests that despite the potential for creativity in performing gender identities, men and women tend to rely on “tried and tested” constructions that are thought of as conventional ways of being (Edley 2000). Individuals generally behave in ways that will reflect the norms of the culture. As Stuart Hall (2000) comments, identities are “the positions which the subject is obliged to take up while always “knowing” that they are representations....” Thus gender is not a property of individuals but instead a socially proscribed relationship which necessarily constricts certain behaviours, such as for men, the direct involvement with care. The following extracts provide examples of the conventional stock of knowledge on male identity, which serve to narrow the range of activities that male caregivers can be involved with. Again the analysis follows the discursive tradition, examining not only the informants’ constructions but also their and the interviewer’s linguistic practices in managing the interaction.

5.2 Male identity as a socially proscribed state

In the same way that cultural norms are used as a resource to support the notion of female superiority in caregiving, men are constructed as having interests that preclude them from engaging in informal care. In other words men “perform” a male gender identity and as a result come to be known as the possessor of a set of masculine attributes. We see this at work in the following extracts.

Extract (23)

Interviewer: And is he involved in personal care at all like bathing and things like that?

Informant DN 1: No, no.

Interviewer: Why is that?

Informant DN 1: I think probably because he's male and, you know, probably doesn't have a lot of time, and I don't think she would have it, you know. I mean he's very good as I say at coming and doing things that sons do, but you know as far as the personal care and things is concerned then you know, she's had people coming in to do that or has been sort of doing it herself.

In the above extract (23) there are a number of points of interest for the discourse analyst. Firstly we see the question and answer structure and note that the response to the initial question is clear-cut and unambiguous. The informant replies with a categorical and repeated "no". A preferred response, within the context of Potter and Wetherell's analysis of preference structure in adjacency pairs, discussed in the previous chapter (Potter and Wetherell 1987). The interviewer explores why the client's son is not involved in personal care and note that the informant hedges in her analysis with, "I think probably". We have seen how phrases such as "I think" can be used as hedges but also that they can serve the purpose of creating distance between the speaker and the utterance that is just about to be produced. Moreover the word "probably" while having no direct relevance to the actual issues being discussed, is of interest in that it further enhances the distance between the speaker and her avowal. In a sense the statement, "because he's

male” is being issued with conditions, and these conditions allow the informant to stand behind the utterance and not wholly own it. By prefixing it with the phrase “I think probably” gives the impression that she is guessing or hypothesizing at a likely explanation but that she herself does not want to claim it directly.

We can see from extract (23) that the informant has produced a variety of reasons to explain why the patient’s son is not involved in administering his mother’s personal care. As well as his sex, the reasons offered also encompass his apparent lack of time, and the assumption that the patient would not wish it. Throughout this stretch of talk it is clear that the informant is presenting the caregiver’s practical circumstances as mitigation against involvement. However what is perhaps most revealing is the comment that “he is very good at doing things that sons do”. The informant is alluding to some commonsense universal knowledge regarding the “normal” role of sons, which necessarily relies on a prior and shared understanding of the male identity. It was not then that the caregiver was unwilling or uncaring. He was male and his maleness was justification in itself. Note also that the client had “people” coming in to administer the personal care. The normative conditions in which a son could admissibly become involved had not arisen as other, more legitimate help was at hand.

As we have seen in earlier sections, a number of authors (Waerness 1987; Qureshi & Walker 1988) have pointed to the gendered hierarchy of caring which casts women in a range of familial relationships as the chief source of informal care work. Male caregivers tend to be the spouse of the recipient of care (Arber and Ginn 1991). In the hierarchy of

care, sons feature near the bottom of the structure as claims on their time are seen as less legitimate by formal service providers and this is evident in extract (23).

There is further evidence of the hierarchy of care in extract (24) whereby the informant identifies the delivery of personal care by sons as inappropriate:

Extract (24)

Interviewer: What about sons and mothers?

Informant DN6: It's a different it's a different eh, the son's very caring towards the mother it's a different kind of relationship. They can't do the intimate caring that a daughter could do, personal care something like that.

Interviewer: Would that be inappropriate?

Informant DN6: I would think so yeah. Neither side would want to get involved in that.

Interviewer: And what would you do in that situation?

Informant DN6: It wouldn't be a nursing problem it would be social work.

Interviewer: Why would that be?

Informant DN6: *Well for one thing I think the two people concerned would be embarrassed and there'd be embarrassment on both sides.*

Interviewer: Is it generally the case that they would say so?

Informant DN6: I think I could just get the... well they probably would but I think as part of the assessment well you know "how do you feel about professional

help, would you want to do that". Most times they would say "no not my son em" anyway.

In the stretch of interaction in extract (24) above the informant firstly refers to the relationship that sons' have with their mothers' as "different" to the relationship between daughters' and mothers'. This has a clear resonance with earlier discussions concerning universal and essential male-female differences and illustrates the dichotomy clearly. Personal care is something that sons' "can't do". Nevertheless they can still be afforded the status of being "very caring", but are not required to demonstrate this through the practical application of care. Within a mother-son relationship intimate personal care in this account is not only constructed as culturally unacceptable but impractical. Both parent and child would find it embarrassing and neither would feel comfortable with the situation. Note the psychologisation again. Not surprisingly the text also suggests that daughters "can do" personal care, which evidences the use of the resource of female essentialism detailed in the previous section.

As a response to the question "what would you do in that situation", the informant replies, "it wouldn't be a nursing problem it would be a social work". With the use of the word "problem" is worth noting that the situation of a son involved with his mother's personal care is constructed as circumstance that would need settling in some way, regardless of its acceptability to the individuals themselves. At the same time with the use of this statement the informant subtly evades the focus of the question concerning what she would do in a case such as this. By replying that it would be an issue to be resolved

by social work, the informant is able to prevent the possibility of advocating an action, which may discredit her.

The interviewer follows up the informant's response with further questioning, enquiring as to whether either party would vocalise an objection to this arrangement. The question is paired with a response that is cut short before completion, "I think I would just get the...." Schegloff, Jefferson and Sacks (1977) describe this type of speech activity as "self-initiated repair". The speaker adjusts their orientation and replaces the unit of information they had begun to issue, with another revised version. Again from a discourse analytic perspective the concern lies in identifying the reasons behind the change in orientation. Although the completed sentence is not available, the orientation is nevertheless hearable and it is clear that in its un-repaired state the informant was straying into the potentially damaging territory of *assumption*. To imply that nursing practices are based upon assumption is incongruent with the contemporary identity of nursing. Nursing has been heavily criticised for its lack of a systematic, problem-solving approach (Salvage 1993). Thus reliance on assumption to inform practice would clearly evidence of the use of "unscientific" knowledge. Therefore in changing the orientation to "assessment", the informant is suggesting that she would know that a woman would not like to be cared for by her son because it would have been part of the assessment process, rendering it *scientifically* derived knowledge.

Note also that the informant goes as far as to "quote" what she would say in the assessment situation, "how do you feel about professional help, would you want to do

that?” From the discourse analytic perspective the concern lies in the change in emphasis and intonation that allows this utterance to be heard as a quotation. We see that the informant does not mark this utterance out directly as an actual quotation, but instead presents the utterance as the *kind of thing* that would be said. As we have seen in the previous chapter this is evidence of “active voicing” and is representative of an accounting technique, which adds strength to claims being made (Woffitt 1992). In this extract (24) the informant is securing her status by not only telling the listener that it would be “part of the assessment” but is also providing evidence in the form of a quotation, an *actual* example of what how she would address the situation. We see also how the *actual* client would respond, “no not my son”.

5.3 Only out of necessity

Despite the form of accounting that questions the suitability and acceptability of men’s caregiving, the account in extract (25) demonstrates how it can be admissible when there is no alternative.

Extract (25)

Interviewer: In your experience do you feel that women are better carers than men?

Informant SCM1: Certainly most of the carers we get are women em. It’s an impossible one to answer and hopefully I’m not being biased because I am a man em I don’t know. I’ve had examples of both. I’ve had some male carers that have

cared for mothers and their fathers and you couldn't better them. I would say what I said before it's women that seem to be, I don't know whether eager and willing are the right words but they seem to be, they tend to step into the caring role as opposed to men. Invariably if you do have male carers they tend to be because they're the only one around there aren't any mothers, wives, sisters.

We have seen this extract in Chapter Four and have discussed its orientation in relation to female identity. Again we see the both the familiar adjacency pairing and the theme of superiority between the sexes. It is notable that the question follows the basic gist of others that have been asked on this theme, "In your experience do you feel that women are better carers than men?" However, analysis reveals a slight and subtle variation in its format with its attendance towards the issue of the informant's "experience". From this we can ask what purpose is served by introducing the theme in this way. Analysis has previously revealed how potentially troublesome encounters are managed by both the informants and interviewer to reduce the possibility of causing discomfort in the conversation. By orientating the question towards establishing the informant's professional *experience*, the informant's personal accountability is reduced. Moreover the phrasing of the question in this way protects against eliciting a dispreferred response.

The theme of caregiving is taken up by the informant and is interpreted as a predominantly female domain in alluding to female care as the first port of call. We see that male caregiving will suffice, but only when other avenues have been pursued. In this case male involvement occurs almost by accident. Men get involved when the legitimate

caregivers, the “mothers, wives, sisters” are not available. Again this resonates with the gendered hierarchy of caregiving offered by Quereshi and Walker (1988).

5.4 Male traits

The theme of male identity is taken further in the following interaction. Taken from a long stretch of talk the informant refers to trait theory, whereby potential male caregivers are constructed as being innately different to female caregivers.

Extract (26)

Informant DN1: It's kind of an instinct you know. To do certain things, you know, for somebody, you know, to wash them or to change the sheets, make sure nighties, basic things like that, you know. I'm not being disrespectful but they can't think of too many things, and I think it's just a male and female trait. They're better at things that we can't do.

In extract (26) the informant DN1 makes further reference to women's natural instinct. They have the necessary traits, which enable them to provide care. Trait theory assumes that individuals can be described according to core characteristics which are enduring over time and ultimately influence behaviour. In this case the core characteristics of the male identity concerns a way of thinking which impedes caring performance and manifests as the failure to anticipate the simple but diverse needs of the patient. However the informant attempts to articulate the idea that she is nevertheless an advocate of

equality with the utterance “they’re better at things that we can’t do”. Therefore men are good perhaps at mending cars and fixing shelves, activities that could be considered linear. Women’s strengths or traits may be seen to lie in anticipating needs in advance of the event. This has similarities with the notion of female intuition, a form of immediate and instinctive knowledge by which women can perceive the truth of things without the need for reasoning. Such forms of accounting draw from the vocabulary of “equality in difference”. One of the difficulties for Sayers (1982) in this approach is that while it seems to salute the condition of being equal it does not challenge the notion of women as the protagonist of domestic labour, which is for her essentially an ideological arrangement.

5.5 The weaker sex!

The following extract (27) again draws on the idea of a pre-existing male identity where male informal caregivers are characterised by character flaws, such as an inability to cope.

Extract (27)

Interviewer: There’s a lot of research on gender and informal care and men are becoming more involved but it’s still predominantly the female role. Why do you think that is?

Informant SCM3: It's just the conditioning. It's just all the stereotypes about women doing all the caring. The maternal thing, just what we are taught.

Interviewer: Have you found that in your experience?

Informant SCM3: Yeah, I mean most of the carers that I deal with are women and often it's the males I deal with, they're the ones that say, "something's got to be done". Just an example of a brother and a sister and it's the sister who's going in and cleaning and bathing her mum, he's the one on the phone complaining about what's happening. It still happens I mean it's a. I mean it has changed. I've been in touch with a lot but as I say a lot of them find that quite stressful.

Here the interviewer again sets up the question in a fairly neutral way by referring to research, providing a non contentious grounding to the question. As a response the informant is seen to respond immediately with an attack on stereotyping and offers "conditioning" as an answer, suggesting that women are trained to accept caregiving as their role. The informant refers to this as just "stereotypes, women doing all the caring." However it is interesting to note that further into the extract the informant herself constructs a version of both male and female nature which is based on such a stereotype. Women are portrayed as having an inherent ability to cope, that they roll their sleeves up and just get on with it. Men however do not get involved in any real sense other than to complain. The version being put forward is that men are unable to bear up to the stresses associated with informal care. As the conventional stock of knowledge associates men with order, power and control it seems that the masculine state of being is uncomfortable with situations that lie beyond direct manipulation. Again such forms of accounting work

to “psychologise” men and in this extract of text both men and women are structured as having particular types of nature.

Secondly the extract contains another significant theme, the idea that the male character is undergoing development with the utterance, “it has changed”. This conveys the message that the male nature is “softening” and taking on qualities that are more female. Contemporary male identity has been discussed in terms which suggest that traditional domestic arrangements are changing. Studies such as that as Young and Wilmott (1975) for example argued that men, particularly husbands have an increasing participation in housework and domestic arrangements. Segal (1990) has suggested that a range of new masculine identities has opened up to men in response to feminism but that traditions are slow to change. Thus we see two forms of accounting in this extract. Firstly gender as a fixed identity, and secondly gender as a dynamic phenomena, which moves as a response to societal forces. From this we must consider the interactional business being performed here. Looking at the detail of the extract again the informant is seen to assert a stereotypical picture of a male informal caregiver, but then works to undermine this by bringing in the “change” argument. Potter and Wetherell (1992 pg: 211) suggest that manoeuvres such as this are an example of “dodging the identity of prejudice”. The informant’s original formulation could be read as adhering to a stereotype, therefore in order to deflect or avoid criticism, we see an attempt to recategorise it as something that is external to the individual. To say that it is changing is to cast it as society’s problem rather than as a personal issue. In addition the informant also moves to construct the

anecdote as an empirical fact by asserting that “I’ve been in touch with a lot”, thus generalising the issue to a wider population.

The ethos and perhaps rhetoric of community care supports an androgenous or gender neutral approach whereby caregivers, in general are to be supported. The issue of the gendered division in informal care is acknowledged. Sharkey (2000 pg. 35) for example, is aware that service providers can make assumptions about the needs of caregivers based on gender and that a way to combat this is to strive towards anti-sexist practice. He comments that, “an anti-sexist approach involves men changing and doing more caring”, but again this utterance is implicative of a type of male essentialism. Change is required and men are being urged to move from an original position towards that of greater involvement. This in itself is a formulation of men. They are positioned as possessing, whether through biology or inculcation, a specific identity, which lies at the heart of the informal care problem. Community care practitioners would presumably be the stimulus for the change.

5.6 Marvellous men

The informant in the extract (28) below is offering an explanation for the predominance of female informal carers, referring to women’s nature but at the same time endorsing the idea that men too can be proficient at caregiving.

Extract (28)

Interviewer: There's been a lot of research that's been done which looks at the number of women involved why do you think that is?

Informant DN6: Oh because it's part of their nature to care isn't it but having said that I've met some marvellous men that have done things that I never dreamt.

They've had to do some jobs in the line of caring that I never thought a man would be able to do. It's amazing. Again if it's a husband and wife relationship its part of the commitment isn't it.

This extract is interesting on a number of levels. Firstly, the account echoes the male-female dichotomy in that the female predominance in informal care is due to the now familiar theme of their "nature". However note that this utterance is qualified with "but having said that..." allowing the account to be heard as fairly neutral. The informant compliments both men and women and this is seen to avoid any potential accusation of gender bias. However on closer inspection it is clear that caregiving is presented as lying outside the true nature of men. That men can administer care is "amazing", even to the extent that it is outside the realm of dreams. Moreover the men themselves are "marvellous" in that they can rise to the occasion and perform unpleasant tasks. Note however that these activities are set within the context of a spousal relationship, and as many of the extracts have demonstrated, this is often the only relationship where male involvement can be legitimately sanctioned. Caregiving, is part of the normative social arrangements within marriage, part of the "commitment". Secondly, the utterance, "They've *had to do* some jobs in the line or caring...", gives the reader the sense that

male caregivers become involved only when circumstances compel. Doing one's duty. In a similar way to extract (25), when there were no suitable, namely female alternatives. Note also that by referring to, "jobs in the line of caring", caregiving is constructed as, and ultimately reduced to, a piece of work. Thus it necessarily becomes physical labour.

The portrayal of the male identity as instrumental, goal orientated, assertive and somewhat less expressive than female identity is common (Wilson 1995). The following extract of text is part of a very long stretch of talk. The interviewer has asked the informant to explain why few men are involved in informal care and the response demonstrates how men are constructed as having difficulties in expressing emotions.

Extract (29)

Informant SCM2: I think we're beginning to see men giving support and I think that men are less anxious now about saying they're not coping where as it was always seen as a sense of failure for a man to be upset or anxious about caring for someone but it certainly is the case that we don't see many male carers.

The informant in this extract (29) provides a rationale for the paucity of men in caregiving roles, suggesting that the barrier has arisen out of the common doctrine of "men don't cry". That to be male is to be in control and cope in all circumstances. This suggests that the normative notion of masculine identity has worked to proscribe male involvement in care. According to Seidler (1985) men have power at the cost of an emotional life and one of the ways that men maintain control is to repress and

compartmentalise emotion. Therefore, men are unable to change if control is to be relinquished.

However the informant indicates that this aspect of gendered personality is gradually being eroded as men begin to feel comfortable in a culturally female role of emotional weakness, the idea being that women are temperamentally better suited to caregiving. In an essentialist argument Gilligan (1983) suggests that male gender identity is threatened by intimacy while female gender is threatened by separation. Women it seems find strength in intimate relationships while men are at their weakest and most vulnerable. Again Seidler (1985) and Chodorow (1978) comment that men lack the language of emotion because of early childhood experiences, which distanced them from their fathers. While Emerson (1985 pg.285) sees men as “distant and inattentive.....they’re always in disguise”. In various ways such authors are themselves *constructing male identity in their* presentation of a body of knowledge, which is used to furnish ways of knowing.

As a balance to these themes informants did talk about male caregivers who were judged to have provided very good care. However it was notable that the standards were constructed as lower than those expected of a female caregiver. The contrast was apparent when individual cases were compared. All of the informants described their involvement in cases where the care was good. However the data suggested that female caregiving while good, is almost unremarkable. See the following examples of talk.

Extract (30)

Interviewer: Have you had experience of informal carers where they gave extremely good care?

Informant DN3: In lots of ways. Patients with a stroke [pause] em

Interviewer: Can you give me an example where...

Informant DN3: Just thinking [pause] The carer's given you know as much as they could at the time. You know they've lifted on and off the commode. They've washed them and fed them and changed them. There's us going in as well for support and back up [pause] there was one woman, she was dying of cancer of the bronchus and her husband err buying her baby food and feeding her it and she was awful skinny and she couldn't walk and he was sitting up with her at night and tried to get a Marie Curie sitter and it was quite late and he was a bit resistant to help. She had a lot of allergies and we went in and she was obviously dying. I think we were only in two weeks from the first visit until she died. She died on Halloween I remember because and he was just fantastic. He wanted to keep her at home and so many of them want to keep them at home.

To return to the discussion on what Sacks et al (1974) term adjacency pairs in conversation we have seen that questions and answers tend to follow a logical sequence. For example we have looked at the preference structure in relation to the response being preferred or dispreferred. It is also interesting to note that questions and answers are also typed in that a question may serve to limit the responses. We see an example of this in extract (30). The interviewer's first question is oriented towards encouraging the

informant to talk about examples of good caregivers, “Have you had experience of informal carers where they gave extremely good care?” However the question is clearly closed and also quite general in its focus and could justifiably elicit the simple response of, “yes”. However, the informant does not reply in this way choosing instead, “In lots of ways . Patients with a stroke em”. According to Goffman (1981), questions tend to set up normative expectations of what type of answer is required and this initial question and answer sequence demonstrates this point the informant is has a normative understanding of the conversational rules governing the interview. Both the speaker and the listener clearly have to work at bringing off a successful and sensible interaction.

The caregiver in the above extract (30) is clearly being characterised as someone who is meeting the needs of his spouse in a very supportive way. He has purchased food that can be better managed by the recipient of care and he is sitting up at night to ensure her safety. In addition he was keen to maintain his wife at home rather than have her admitted into formal care. The account culminates in the caregiver being described as “fantastic”. We see a similar utterance in the following extract.

Extract (31)

Interviewer: there been a lot of research that’s been done which looks at the number of women involved why do you think that is?

Informant DN3: Oh because its part of their nature to care isn’t it but having said that I’ve met some marvelous men that have done things that I never dreamt. They’ve had to do some jobs in the line of caring that I never thought a man

would be able to do. It's amazing. Again if it's a husband and wife relationship its part of the commitment isn't it.

The stretches of talk in extract (30) and (31) suggest that male caregivers can be described in a way that accentuates them as virtuous. They almost confound expectations by being proactive and expressing a desire to continue as the primary caregiver or to engage in tasks which are perceived as unusual. In general terms they can be described, as in extract (31) as "marvellous". Promerantz (1986) discusses the ways in which people use extreme points to make a particular emphasis. With the use of such terms the informants are drawing attention to the idea that the male caregivers can be not just good but "fantastic" or "marvellous". An important consideration within this context is that the informants are concerned with the business of ensuring that they present an account of informal care which is seen to be neutral. Therefore the descriptions serve the particular activity of avoiding the perception that informants may hold sexist views. In addition it seems that in exclaiming male care as a virtuous and laudable activity informants are necessarily affording it a particular status, that as inherently uncharacteristic of the male identity. To describe it as fantastic is to turn it into something separate from the ordinary, the ordinary being female care. Although the discourse analyst does not treat informant's accounts as if they were pathways into "real" events, it is worth noting that the anecdotes about male caregivers in all but one of the interviews were said to be engaged in the care of a spouse. Moreover from a discourse perspective the interest lies in the representation of male caregiving as an event that is sanctionable within certain "legitimate" contexts, such as in a spousal relationship.

In extract (32) below we see a similar structure to the account. The informant draws on the extreme case formulation by reporting that the patient's husband was "very very upset" and "very very good" at running errands.

Extract (32)

Interviewer: How much was the patient's husband able to do and how much was left to the daughter?

Informant DN6: He didn't do much. He sat with his wife. He was very very upset that it had come to this. He found it hard to accept it but he sat with her. He was very very good at going to get the messages. He felt that that was his contribution he would go and do that but he was there. He was there all the time.

Again the focus for discourse analysis concerns what people do with language and therefore examination of the data must centre on why terms such as "very very good" are used, and to what end? We see from the extract that the male caregiver "didn't do much". It is implied that the carer did not engage in meeting his wife's needs for personal care such as bathing, toileting and lifting. It is worth noting at this point that the majority of the district nurse informants linked care with the administration of nursing activities and made little mention of other constructions of caring for example, an emotional relationship (a topic that will be covered in a later section). Silverman (2000) building on the work of Sacks (1972) suggests that societies link certain types of activities with membership of particular social identities. For example a nurse, may be linked "common-

sensically” to the performance of a range of activities associated with that particular social identity, such as bed-bathing and dressing changes etc. However we see the informal caregiver in extract (32) described as a caregiver who “didn’t do much”. He therefore did not engage in category bound activities, activities associated with his category of caregiver. This creates the possibility for a negative moral assessment as he is seen from the text to have avoided activities, which are appropriate to his social identity. Thus reporting that the carer did none of these carries with it the potential to portray him as uncaring. Therefore after initially presenting the carer as problematic, the informant must work at restoring him to the status of a caring person. Using terms such as “very very good” achieves the purpose of restoring his social identity by building up his qualities and countering any alternative suggestions that he was lazy or distant. Furthermore, the contributions he is described as having made such as sitting with his wife and running errands may not be seen as legitimate caring activities which again creates a requirement to reinforce the description of him as a caring person.

An important aspect of this description is that the *informant* appears to accept these activities as legitimate forms of caregiving. Arber and Ginn (1999) discuss the degree of involvement for men in the administration of personal care and it appears that personal caregiving by men is culturally unacceptable to both the carer and the recipient of care except in the case of spousal relationships. Women however are more likely than men to be involved in the administration of personal care across all relationships whether to same or cross-sex recipients. Indeed Arber and Ginn’s analysis of data from the General Household Survey (1991) found that although personal care is provided less often to non-

resident than co-resident recipients, the gender difference is significantly greater with twice as many women as men involved. In addition the data suggests that twice as many women provide personal care to their mother-in-law as male carers provide to their mothers. Men it seems rely on their wives to fulfil kinship obligations in the performance of personal care. However the male administration of care is by no means unusual particularly in relation to the care of a spouse, but as Arber and Ginn comment, men provide fewer hours of care each week and are less likely to be the main caregiver.

When personal care is perceived to be unacceptable the state community care services play an important role meeting personal care requirements. As greater numbers of women are involved in caregiving it seems reasonable to suggest that it is more difficult for women to side step such tasks on the basis of personal antipathy. As it is not culturally problematic for female informal caregivers to provide personal care, it follows that professional carers may be less accepting of personal repugnance expressed by female carers. It seems that the gendered norms of caregiving in relation to cultural taboos determine what is considered legitimate caring activities and it begs the question, would running errands and sitting with the recipient of care be accepted as legitimate caring activities were the informal caregiver female? The informant appears to have accepted the caregiver's antipathy towards the administration of his wife's personal care as a valid response and from this point it seems that she is drawing from a gendered evaluation of informal care.

Evans (1997) draws our attention to the valuing of male over female by investigating the privileges that male nurses experience over female nurses. She contends that within the formal care environment male nursing staff are treated as valuable and unique because of the small numbers of men entering the profession. For Evans women nurses either consciously or unconsciously support and nurture the careers of male colleagues. Drawing from the work of Paulo Freire (1993) she suggests that this is characteristic of the way that oppressed groups tend to subordinate their status and internalise the norms and values of their oppressors. Commonly the powerful group are epitomised as the best that can be achieved and the oppressed groups admire the oppressor's behaviour. Citing the work of Kauppinen-Toropainen and Lammi (1993), Evans states that male nurses tend to engage in task oriented nursing rather than people-oriented behaviours and that this lack of association with the feminine traits of nursing are reinforced. There are obvious parallels to be drawn from this within the sphere of informal care. Indeed the data suggests that male informal caregivers in certain contexts are privileged over female. It is this focus on task-oriented behaviour that earns male informal carers the privilege. Interestingly involvement with touch and intimate care is regarded with suspicion.

5.7 Male caregiving as deviant

We have seen that the *male identity* forms of accounting are informed by cultural representation, which characterise men as having a particular psychology. Men's identity has come to be understood in the light of "facts" that are known about them and these descriptions have become hegemonic. Such cultural representations have produced a

version of masculinity, which imposes limits on what can be defined as normal behaviour for men. The male gender identity is constructed as having interests, which preclude them from caregiving, therefore men who choose to become involved particularly in intimate care are constructed as deviating from that culturally determined norm. For example, Evans (2002) found concern among male nurses that their caregiving is regarded with suspicion. Stereotypes of sexual aggression or homosexuality work to sexualise their touch, resulting in feelings of vulnerability among male caregivers.

Foucault's perspective has made a significant contribution in this area. It concerns the idea that individuals operate within a body of knowledge, which is relative to a particular period in history and that ways of knowing are bound within what is expressed in discourse. For Foucault, objects are made up of the statements, which name them, but such statements are bound by the specific historical and cultural context. This is not to suggest that Foucault was interested in the investigation of discourse at the micro-level, instead his concern centred on the construction of topics through discourse as "a system of representation" (Hall 1997). For Foucault what is said and done, are one and the same and therefore discourse is about both language and practice. It is through discursive practices that objects are brought into being and make their appearance at particular historical moments, citing "madness" and "sexuality" as examples. These objects can only exist within the discourses about them and such discourses organise conduct and understanding. The following extract is a very long stretch of talk and provides an example of a particular way of seeing the object of "main carer". The informant is

recounting a story of a patient whose son gave up his job to become the full-time informal caregiver.

Extract (33)

Interviewer: Now a lot of care is given by women, certainly according to the research. Now why do you think that is?

Informant DN 3: Well there's one thing that women live longer and for year one and year two that a third were men so one third were women em it's a culture thing you know, that you cared for your children and you cared for your parents and if it's a young girl left at home, and two brothers, its more expected by everybody that it'll be her that'll be the carer rather than the boys even though she could maybe have a better job than the boys and it makes more sense for the boys to be the carer. I'm trying to think. We've got a lady just now whose had a stroke her son looks after her and he said he's given up his work to look after her. I don't know what his job was and he says "I'm the main carer" and I said oh and he's quite young and that's unusual. I haven't seen that for ages it's normally the husband but more often than not it's the wife or the sister or daughter.

The interest in this extract (33) is to be found near the end. The informant is expressing her surprise at an unusual case of a male caregiver who has given up his job. She had noted that the son was quite young, but what made this situation more unusual was that it did not conform to what in her experience, was the conventional pattern of caring

relationships. For the informant a main carer is usually personified as a spouse, a sister or a daughter. This implies the object “main carer” is as Foucault suggests a subject position as it is a role located within a particular meaning. Subject positions are figures who personify the way of knowing in that they have the attributes by which they have been defined.

To be a main carer means to be a spouse of the patient or to be their sister or daughter and the informant by expressing surprise at this situation is operating within an episteme of what is known about gender and informal caregiving. This presents as a problem in terms of legitimacy for the subject in that for the meaning to make sense the subject must locate him/herself in the subject position. In this case the ideal subject position, which the discourse of *main carer* has constructed, is a spouse or female. In addition note that the informant in extract (33) brings in the caregiver’s employment status with, “he’s given up his work to look after her. I don’t know what his job was.” This is of interest to the discourse analyst for what it infers about its relevance. A significant aspect of the discourse on informal care concerns the financial impact on individuals who are involved, particularly in relation to restrictions that caregiving imposes on access to work. Arber and Ginn (1995a; 1995b) for example found that co-resident caregivers were far less likely to be in employment outside the home. As women bear the greatest responsibility for informal care then it is clear that they in particular are more likely to have to give up work to take on a caregiving role. It is therefore pertinent that the informant in extract (33) remarks on the male caregiver giving up his paid employment and the nature of the previous employment is clearly of some relevance, “I don’t know

what his job was". It is possible to hear the attributional relevance of the utterance in terms of the implications for the status and salary attached to the employment. If the job did not attach significant status and salary then resigning to become the "main carer" might be justifiable. Indeed a man to giving up their work to caregiving is remarkable in itself within this utterance.

Note also that in recounting the story the district nurse responds to the male carer with "oh". According to Heritage (1984 pg. 299) *oh* is used for a number of reasons but primarily to symbolise that the producer has undergone a change "in his or her locally current state of knowledge, information, orientation or awareness". The informant in this interview uses this technique with some frequency when giving accounts of her feelings about male carers. See for example the following extract, which follows directly from the previous stretch of talk in extract (33):

Extract (34)

Informant DN 3: She's just being getting a new bathroom and she's been trying it out and I said how did you get on and she said "my son helped me" and I said oh.

How are we to understand the use of *oh* in this way in extracts (33) and (34)? In these instances "oh" is used to demonstrate that the informant had not anticipated that a young man would describe himself as the main carer. The informant, it seems is reorientating herself in the light of this new information. As Schriffin (1982) points out the basic goal of talk is to exchange information and as such interaction necessarily involves the re-

evaluation of old information in the light of the new. *Oh* is therefore used for the benefit of the hearer as a marker to verbalise that knowledge has been recognised, received, replaced or re-evaluated. Further, the informant is expressing some surprise at being faced with a situation when a female patient has received assistance in the shower from her son. Clearly this is being constructed as an unusual case.

In addition this particular informant makes frequent use throughout the interview of the technique of “active voicing” such as “I said or “he said”. For Wooffitt, active voicing allows the speaker to corroborate the story by including evidence from the other actors, which were in this case the male caregiver. Active voicing works to give life to characters in the story by providing them with a voice to substantiate the events.

Chapter two made reference to the cultural taboos concerning the male administration of personal care. That there was a common conception that men, should not be involved in tasks centring on personal hygiene and toileting (Ungerson 1983; 1987). What is perhaps clear from this is that men who are involved to that degree are deviating from the expected role, which constructs caring work as necessarily female work. See the following extract as an example:

Extract (35)

Interviewer: Have you been involved with caregivers where you felt uncomfortable with the care given by a son to his mother?

Informant DN 1: There's maybe some situations where you know, and its maybe just a personal thing where you think he's a bit odd, though that's not a nice thing to say but I'm sure you know we've all done it and em but maybe we think he's just odd because he's one of the few that actually do, you know, care, you know, physically care.

The informant is replying to a question enquiring if a son caring for his mother would make her uncomfortable. We can see that the informant finds the possibility problematic because it is presented as an unusual situation. What is more notable is that the carer is described as "a bit odd". Referring back to previous literature, we can see that perhaps the impetus for this stems from the construction of male identity as potential abuser, unable to control impulses (Connell 1995). In addition the informant is attempting to justify her stance by appealing to common sense and logic with "you know we've all done it". She perhaps is aware that what she has said may be construed as discriminatory and as suggested by Goffman (1981) is attempting to report her claims as if they were the claims of others or citing it as a form of normative behaviour. Note also the informant's representation of caregiving as something physical. Female caregivers can undertake a more holistic form of caregiving including emotional and physical whereas men are restricted in the amount of caregiving they can do *to the body*. The informant makes reference to the implication of abuse with an interjection, which immediately follows the stretch of talk in the previous extract (35).

Extract (36)

Informant DN 1: I mean there's never been any reason for me to think that anything has been going on, there's you know any abuse or any kind of strange behaviour, you know, noticed anything that I should, you know, reported or anything like that.

Again the informant is further emphasising the strangeness of the situation. She hasn't "noticed anything" worth reporting, or did not think that anything was "going on", perhaps implying that although no actual evidence was there to suggest abuse, the possibility was not discounted. However the theme of abuse can be tackled head on as extract (37) demonstrates.

Extract (37)

Interviewer: Have you had situations where an elderly parent had been cared for by their children?

Informant SCM3: I had one situation where the lady had dementia. The son was quite young. They lived together and he was caring for her but that was [pause] I actually felt that there was a lot of risk involved in that. I actually felt that there was abuse, financial and emotional going on which I found very difficult to prove but that one wasn't just because he was put in that caring role, there was a long history. I did feel uneasy. She actually had quite a good home care package which he cancelled because he said he was managing to do it and that made me feel quite uneasy.

There are a number of issues to be drawn from extract (37) above, which present the male caregiver as unusual. Firstly the speaker brings in age as an important issue. The caregiver is described as being “quite young” and is as such unrepresentative of the usual profile of informal caregivers. The question being asked is why would a young man be engaged in caring for an elderly demented parent? Secondly the informant says that there “was a lot of risk involved in that”, but she found abuse “very difficult to prove” meaning that she lacked real evidence. She had a hunch or a sense that this was an abusive relationship. The informant is aware that the care of individuals with dementia can be extremely taxing, leading to depression due to the total subordination of the caregivers own needs. It is also acknowledged that such stresses can be compounded when the informal caregiver is an unwilling participant and abuse can result as carers try to establish control over a situation which is “running away with them” (Bibbings 2000). However with the utterance that it, “wasn’t just because he was put into that caring role”, the informant is discounting this as a possible reason for the potential or suspected abuse.

Smith (1990) demonstrates how representations of abnormal behaviour can be worked up in discourse, which allows the listener to hear the oddness of a particular behaviour. We see from the extract that the caregiver “cancelled a good care package”. It is difficult to see why this could be thought of as an indicator of abuse, particularly as health and social services come under increasing financial pressure. Certainly the focus of community care is cost containment through the replacement of expensive formal resources with less costly informal care and in other circumstances cancelling a care package and conserving

valuable resources would be commendable. However in this extract the informant is using this as a cue to the listener that this is an odd situation. The particular representation being worked up by the informant is orientated towards describing the situation as non-routine or abnormal. It is not normal for a young man to choose to care for his elderly dementing mother and cancel the services put in place by the care manager. Caregiving by men and particularly sons is not normative behaviour and to be engaged so, rings alarm bells within service provision. Squires (1995 cited in Evans 1997) comments on the decision made by the board of management in an American hospital which banned male nurses from working in obstetrics and gynaecology, providing evidence at the unease in men having access to female genitalia in the care setting. Clearly men are better suited to deliver some care and not others.

It appears as if the delivery of personal care by sons is defying an implicit law of nature and that such a challenge would ultimately have consequences. The following extract (38) is a long stretch talk and demonstrates how the informant makes the link between delinquency and the delivery of personal care. The patient in focus was described as a relatively young woman with multiple sclerosis who had a high degree of dependency. Her fourteen year old son had been going home at lunch time to check on her.

Extract (38)

Interviewer: And how do you feel about that. He's given up his job to care for her and presumably he's doing personal care as well?

Informant DN 3: Well he helps her in the shower, yeah he does. She's just getting a new bathroom and she'd been trying it out and I said, "how did you get on"? and she said, "my son helped me" and I said "oh". I think it's very awkward expecting boys to do personal care for their mum and I can think of a girl that I've had, she's very bad with MS. She's not my patient but I've seen a lot of her but her fourteen year old boy, I don't know whether he's still but at the time he was expected to change his mum's pad and everything at lunch time and I just thought, that's just not on. I've got two boys that age and I wouldn't like anyone of them to change my nappy at lunchtime. He ended up in a lot of trouble that boy and he was taking money out of her purse and I'm sure it was all the stress he was under.

The informant is drawing on a situation, which supports the theory that in the hierarchy of care, sons should have the least involvement by virtue of their maleness. That being male rightfully precludes them from intimate care. The delivery of personal care is abnormal or unhealthy in terms of the stereotypical notion of male identity, and as such would lead a straight path to delinquency. While the previous samples of discourse have been selected to illustrate the use of repertoires, which constructed male care as deviant, we see from this extract that male care can be implicated in a causal relationship to deviancy. Certainly the account suggests that the son took to stealing from his mother's purse as a result of the stress he was under. It is also worth noting how the informant refers to her own situation and experiences of family life with which to gauge the

acceptability of a behaviour. The response continues in some detail but we pick it up later after further discussion in extract (39).

Extract (39)

Informant DN 3: [pause] But em I don't think it's right em I mean this girl still had her periods you know she wasn't sixty or anything and I don't think that this boy should be doing all this for his mum. Under that sort of pressure.

In extract (39) we see that the age of the client is a factor, that if the client is relatively young then the level of unacceptability is heightened. For Lovering (1995) the female body is considered to be shameful, particularly with a remaining reproductive capacity, which constructs it as essentially sexual and it is notable that menstruation continues to be a taboo (Laws 1990). By way of contrast, a daughter's involvement would be acceptable, and to support this position the informant draws on ideas of what is normal using female biology as the backdrop to this. See for example the following extract (40):

Extract (40)

Interviewer: So do you think there's a gender assumption about that?

Informant DN 3: Yes I suppose there'll be. With us [pause] if it was a teenage girl I would view that, I would hope that I would still think about her in the way that I would about the boy. It wouldn't strike me as so unusual because a girl, you know, she knows about periods and sanitary towels so it won't be bad for her changing her mum's.

It is interesting to note that the informant associates no stress or difficulty in this case. No evidence or opinion was offered to suggest morbid sequelae as the result of the daughter's involvement in her mother's personal care because girls, "know about periods and sanitary towels, so it won't be bad for her changing her mum's". Again Lovering comments on the dominant practice of concealing menstruation so that boys and men are largely unaware of it and thus within western society menstruation has come to mean the intimate, private and sexual female body. The female body belongs to "private" discursive practices, rarely discussed between the sexes and therefore for a male to have direct involvement in menstruation would be to break a strong cultural taboo.

Extract (41) below provides further evidence of how male informal caregiving can be constructed as deviant. In this long and detailed the informant discusses a male caregiver who's actions are characterised as less than satisfactory.

Extract (41)

Interviewer: Can you give me an example of a case that you've recently been involved with?

Informant SCM5: Yes sadly there's a husband and wife and the husband's been very supportive. His wife is a very frail woman. She unfortunately, they were inseparable. They'd go everywhere together until she had an accident on a bus. He was very reluctant to accept services. No doubt it was the cost but he had a really good income. He had [pause] there was nothing I could do to increase their

income, they had all the benefits. Anyway she was going to be discharged from hospital and we encouraged him to visit her once a week in rehabilitation to show him the right way to [pause] give him some insight because in his kindness he was manhandling her in a way and challenging her abilities and making her do more than she was capable of. It was clear he didn't have the skills but he was determined he wanted his wife home. So she went home and she did require a lot of direct services just to get her up and washed and dressed and comfortable. Skin care, catheter care, pressure area care. Husband will look after her during the day and then someone will come in at night and get her undressed and into bed. But it was the cost and it had been fully explained to him. He could afford it but it was the principle. He'd paid all his days, tax and stuff. Finally I got him and her sat down. Very difficult to get an honest opinion and her husband saying, "you can manage can't you, you don't need someone to come in every night". So eventually we had to relinquish and that was stopped, got the bed down stairs and what have you. But until they went on holiday they were still accepting services coming in every morning and when they came back it was "thanks but no thanks". Didn't want any more to do with these services and she was prepared to go along with what he says but within a fortnight it was clear that she was in a bad way. I went out with the warden and I've never seen such a change in her. He was determined that she was able to walk and his attitude was "you're just encouraging her laziness". I'm not medically qualified but I could see the fluid and we got the doctor in and she was admitted to hospital. The bottom line is that she died just last week.

Extract (41) follows the familiar form of a narrative account of a series of events recalled by the informant. The narrative can be analysed to reveal both its pattern and its action orientation. To consider the pattern of the narrative first, Labov (1967 pg. 225) defines narrative as a “method of recapitulating past experiences by matching a verbal sequence of events which actually occurred”. Bell (1991) in adapting Labov and Waletzky’s (1967) analysis of the structure of narratives states that there are six key elements which typically occur:

1. A story-teller can often summarise the central action and main point of the narrative to pre-empt questions; what is it about, why is the story being told?
2. The orientation sets the scene; who when, where, and initial situation or activity of the story.
3. The complicating action is the central part of the story proper answering the question, what happened (then)?
4. The evaluation addresses the question, so what?
5. The resolution is what finally happened to conclude the sequence of events.
6. Many narratives end with a coda – “and that was that”. This wraps up the action, and returns the conversation from the time of the narrative to the present.

(Adapted from Bell 1991 in Jaworski and Coupland 1999 pg. 237)

Using the example of extract (41) it is possible to draw structural comparisons between these elements and the text. Although it is common for narrators to begin with a summary, the story in this extract does not use one. Nevertheless the informant sets the scene by providing details of who, what and why. From the beginning of the stretch of talk we see a sad situation where a woman is injured while getting on a bus and the story unfolds to an even worse conclusion. We can also see elements of the complicating action and evaluation as the narrator provides a number of points to indicate what happened and why it should be of interest. In terms of the final result the patient's admission to hospital as a consequence of the action concludes the events. As Bell suggests, the narrative ends with a coda, 'the bottom line is she died just last week', serving both purposes of bridging the gap between the time of the event and the present and to bring the subject to a close.

It is clear from this brief overview that narratives, regardless of the topic typically follow verbal sequences whereby the narrator manages the direction and controls the story to maintain the interest of the listener. In this area Promerantz (1988) agrees that when an event is being described the success of the description is dependent upon how it is managed. The narrator therefore, controls the detail in terms of what to include or leave out in order to give the story a logical and coherent flow and to demonstrate a particular point. In addition listeners are also aware of the possibility that descriptions can be motivated by the narrators interests, desires and stake, so there is no guarantee that descriptions will be accepted as accurate or literal by the listener. Acceptance is something that has to be worked towards, it cannot be taken for granted. If descriptive

information is managed in this way it is clear that events may have alternative descriptions and that the version given may have been worked in order to achieve a particular purpose. This underpinning assists in understanding how descriptions can be orientated to an action.

The question that is then presented is, why this version? What purpose is achieved? What actions is the narrative orientated to? The crux of the narrative concerns the caregiver's refusal to pay charges for his wife's care and as such we see that the description being offered is a direct challenge to the caregiver's moral identity. He is accused of putting money before the welfare of his wife so in order to carry this off and present it as a believable account the informant has to work up a narrative, which shows evidence to support the judgement.

First of all we are told that the caregiver had a "really good income" therefore we are expected to discount lack of financial resources as a motive for his antipathy towards formal services. Next we see that prior to discharge the caregiver was asked to attend training sessions to educate him in the techniques of moving and handling his disabled wife. From this we can see that any rough treatment the woman received was not due to ignorance or lack of preparation. As further evidence the informant uses a feature of interaction called a "three-part list" when delivering the details of the care that was required, that is "skin care, catheter care, pressure area care". Noted by Jefferson (1990) three-part lists are a common technique which serve the purpose of summarising and giving a general flavour. Three-part lists imply a general class of things so what we can

draw from the list is that the woman did have a “genuine” requirement for care, as her needs would exceed the technical abilities of most informal caregivers. Indeed the list is also useful as a means of subtly suggesting that these activities may not be appropriate for a male caregiver. By presenting the care requirements in this way the informant avoids the risk of being perceived as having any dubious ideological beliefs with regard to gender.

With further analysis we see a return to the issue of financial motivation with, “it was the cost and it had been explained to him”. The point here is that the informant is able to inoculate against the idea that the carer was duped into this position or led on with false promises or perhaps ignorant of what the actual costs would be. However the carer’s motivations are principled in that he regarded free care as his right having “paid all his days, tax and stuff”. From this the caregiver is presented as someone who is driven by a doctrine rather than concern for his wife’s welfare. At the same time the woman is presented as passive under a domineering husband, too afraid to express her feelings. He put words into her mouth, “you can manage at night can’t you, you don’t need someone to come in every night”, hence the informant’s use of active voicing to demonstrate the point.

The patient’s decline is described and as a means of constructing factuality the informant brings in a witness in the form of the warden to corroborate the events. According to Edwards and Potter (1992) accounts that incorporate an independent witness are made more credible in that they add weight to the claims made by the speaker. As readers we

are not concerned with uncovering the truth about whether the warden was actually there with the informant or not. The concern centres on possible explanations of why the informant chose to impart this piece of seemingly irrelevant information. The witness is relevant to the account because by saying that someone else was there the informant is building up a factual account.

As the patient's health continues to decline so does her husband's moral status. We see further use of active voicing with "you're just encouraging her laziness" to corroborate the events and cement the caregivers characterisation as wilfully neglectful. The patient's illness becomes acute and to mark this as a dramatic event the informant uses the phrase "I'm not medically qualified but I could see the fluid". Again the concern of the discourse analyst is not to uncover the truth of the statement but to consider the reason for its use. One possible intention is to add a vividness that presents a clear and striking picture of the extent of the caregiver's misconduct. Edwards and Potter (1992) comment that as narratives always have a beginning and an end, so too are there choices about when and how to complete them. *In the case of this account the narrative is brought to a dramatic end with the death of the patient.*

As suggested the point of this narrative is to show the moral identity of the informal caregiver. The phrases used in the description clearly implicate him in the demise of his wife. The set of descriptions include his unnecessary thrift, his misguided principles, lack of skill, physical roughness and his bullying treatment of his wife. The picture built up is quite powerful and effectively shows the man to be hopelessly inadequate as a caregiver.

With the deployment of a mixture of description and “facts” mustered to corroborate the account, the informant has successfully managed the narrative to “bring off” the construction and to have it accepted as a convincing story.

5.8 A gendered dimension of the inverse care law

Levin (1989) highlights elements of the inverse care law in relation to informal caregivers. This centres on the idea that those who are seen to manage in difficult circumstances without help from formal agencies are often those in real need of support. Conversely those who are seen to collapse under the strain of caregiving are rewarded for their apparent failure and are given extra service resources in order to maintain the patient in their own home and prevent hospital admission. This is certainly relevant to the following extract. The interaction centres on male informal caregiver works full-time in his own business and also tends his chronically ill spouse.

Extract (42)

Interviewer: How do you know that carers aren't coping?

Informant DN3: Phoning between the planned visits and over anxious about absolutely everything em [pause] like this man who's working full-time. He phones a lot now and I suppose in a way I'm spending a lot more time supporting him. I'm not actually doing anything for the patient because her care is all being provided really by Crossroads and we're sort of overseeing any problems as they arise but I'm not sort of her caregiver and I'm supporting him and he phones for

silly wee things. Mesh pants when he only had them two weeks ago. I'm sure it's always just an opportunity to speak to you. He'll phone and say "do you want to pop around to the office for a coffee" and I'll say to him, "I'll see you at the house".

The caregiver has been suggested as an example of someone who isn't coping. He is described as someone who contacts the nursing service unnecessarily, asking for things that he doesn't need and requesting visits when there is no valid nursing reason. It is clear from this extract and others to follow that the patient has a very comprehensive care package in place, involving a range of service providers, incorporating social care and district nursing services, Crossroads voluntary service and Marie Curie night sitters. The care package also includes regular respite care and these services together are described by the informant as costing more than a place in a nursing home. The caregiver, as well as receiving this support is also in receipt of district nursing support by way of extra visits that are in essence social calls. This is representative of what Twigg and Atkin (1994) refer to as "the superseded carer". That is, formal service providers have entirely replaced informal input.

This is representative of the paradox in the response of formal services to informal carers. In addition it also serves to highlight the difficulty in deciding who is actually the patient or recipient of care in such a case. The patient has traditionally been portrayed as the central character in receipt of care. However the movement towards "holism" has muddled the waters. The clinical gaze has shifted focus away from the patient as a

distinct entity, towards the conception of the patient as an occupant of a social space. Through community care the patient can no longer be considered in isolation as the sole beneficiary of care. Clearly the extract suggests that while the nursing needs of the patient may have been successfully addressed, the carer has needs, which the service provider may choose to meet, hence the ad hoc visits.

The informant continues through the interview to build up a picture of why this carer was offered up as someone who is not coping and brings in several examples to support this position. A range of episodes had led her to this conclusion and this culminated in an attempt to get to the bottom of the problem. See extract (43):

Extract (43)

Informant DN3: And at one stage I had to say “right, come through” and I sat him down and because I wasn’t sure all the messages I was getting and I said “do you want her to go into a nursing home” because he kept saying “well it’s just a matter of time” and “I’m seeing the consultant and he said to keep her in bed” [pause]. “She’ll get a chest infection” and he’s the first one to say when she starts coughing “I want her on antibiotics”. So you know he wants all the treatment but he wishes she would die because she’s been ill for ten years [pause] and the marriage is over and he’s in a really difficult situation. He’s not an old man.

To justify his position as a paradigm case, the informant presents the caregiver as someone who is in a difficult situation. He is committed to caring for his wife who has

been ill for many years but is naturally torn between this commitment and wish to lead a normal life. He is presented as a man who is still young enough expect something more from a relationship. The informant is drawing on a range of resources, which are used to emphasise that he is a caring man, he has his wife's interests at heart in that he is keeping her at home. He is fulfilling his marital obligations.

Again, focusing on the inverse care law we can see that the caregiver is being rewarded for this commitment with a very supportive care package that runs on some days to 24-hour care. Cost has been and continues to be a significant factor in care provision and it is *interesting to note that in exceptional cases the care plan will support provision that is clearly more expensive than the alternative.* Twigg and Atkin (1994) found that service providers lack a clear rationale for involvement with informal caregivers. However there must be some underlying principles, which inform decision-making but such endeavours run the risk of slipping into a cognitivist framework. Nevertheless, at the heart of this account we see that the informal caregiver has been presented in a number of ways, namely as male, a full-time businessman, relatively young and the carer of a chronically ill wife. See extract (44) below:

Extract (44)

Interviewer: And do you feel that caregiver's needs are being met?

Informant DN3: There's a big gap in respite care for some patients em some carers really want to keep their relatives at home and so if you can't put in enough care they just end up getting totally frazzled. We've got one lady now who's

husband works full-time. He's got his own business, em she's got dementia now and she needs washed, fed, she calls out in the night. He's got a full care package Monday to Friday. Crossroads look after his wife when he's a work.

As readers of this stretch of talk and others we have ideas about what it signifies to be described in this way. From the details given a picture is emerging which is orientated towards a certain kind of action namely to present a particular picture. To look at this in more detail we need to turn to the work of Sacks (1972, 1974) and his explanation of the use of categories in discourse. Sacks focused on the way that categories are used to make subtle inferences about people to allow particular evaluations to be made. The descriptions of "male", "full-time business man", "young" and "carer" are all categories which command a particular status and are therefore displays of his position in society. However the focus is not on the categories themselves but the purpose they serve in terms of the interaction at hand. At this point we are asking, what is being done with them and how are they significant? They are significant to the interaction in that they are given to allow the listener to hear them and draw commonsense evaluations from the category terms. They are relevant to the story as justifiers for having a supportive care package and thus the informant is "bringing off" an acceptable account.

In a previous section it was demonstrated how the male caregiver involved in personal care was constructed as potentially deviant or odd. However in this recent example in extract (43) the informant talks quite explicitly about a male caregiver who actively looks to situations, which might bring about the demise of his wife (the example offered

concerns bringing about a chest infection). Why is this not portrayed as a deviant or odd case? How are such behaviours or thoughts justified? It is clear that the informant is drawing from a conception of a *normal* marriage and *normal* male needs. The caregiver has cared for his wife for ten years and is still relatively young. He aspires to a better way of life with an equal partner. He is in a difficult situation and “the marriage is over”. Commonsense would have it therefore that wishing one’s wife dead, is understandable in such a predicament.

5.9 Chapter conclusion

This chapter has presented data evidencing the range of linguistic and knowledge resources available, which enable informants to talk about male identity in informal care. In a similar way to female identity in the previous chapter, male identity is represented as a fixed state. The statements and narratives used by the informants define men sometimes as lacking the characteristics for care. In some cases we have seen that men can *care* but cannot or are prevented culturally from engaging in *care giving*. Thus men may be involved with informal care, but their ‘true identity’ constrains any input to doing “things that men do”. This chapter has also demonstrated how informants’ accounts construct male involvement in the delivery of personal care as inappropriate. Indeed the discourse reflects the “state of alert” produced as a response to the male administration of personal care. However the involvement of men is sanctionable within certain social contexts such as in the absence of a female caregiver, or in a spousal relationship. In addition the data highlighted the deployment of an argument which suggests that while care may be

demanding and stressful for men and women alike, it lies outside the boundaries of the healthy male identity, embedded in the notion that it is strange. The informants drew on a series of repertoires, which interpret male caregiving as odd, potentially abusive and harmful if not for the patient then for the carer himself.

As suggested in earlier sections women have generally been characterized as nurturing and because of their lack of physical strength, more suitably engaged with emotional rather than physical labour. However from the extracts of talk provided an apparent reverse is noticeable. It seems within the bounds of the caregiving role that an altogether different construction of the division of labour is in existence. Men can be involved in caregiving predominantly providing emotional labour, while women are compelled to engage in physical labour. We have seen that men can be deemed “marvelous” and “very caring” by being engaged at an emotional level, such as being upset and showing concern. At the same time, men who engage in caregiving as physical labour are constructed as deviant and “odd”. For women to be involved at a solely emotional level seems an abandonment of duty.

It has been pointed out that objects can only be constructed from the ways of knowing that are available and that ways of knowing are formed from cultural, social and historical resources. This chapter has provided evidence of a construction of gender that is constrained by these resources. As well as the construction of gender, the data analysis also considered the functional aspects of language. The interaction was analysed to reveal how discourse is organised to achieve certain goals. For example discussion has focused

on the organization of interaction as a means of generating coherence between questions and answers. Evidence was also provided concerning the management of professional identity and the avoidance of criticism or negative attributions. In addition the use of narrative was analysed to reveal their structure and their function as a method of fact building.

Chapter six will go on to provide further evidence of these conversational practices and at the same time consider the construction of *good* caregiving. Further to this, comparisons will be made between the two occupational groups under study to reveal any similarities and differences in accounting practices.

Chapter six

Success in informal care

6.0 Chapter introduction

In Chapter five, discussion centred on the construction of a pre-existing male identity that is not predisposed to informal care. While the data is supportive of men's involvement at a general level, it only becomes legitimate within certain socially prescribed contexts, such as a spousal relationship or in the absence of a woman. Moreover the data suggested that male administered care is open to the accusation of deviancy if it is outside the confines of a socially legitimate context. Chapter six concerns the construction of an "ideal type" of informal care that is characterised as a form of clinical competence and professional insight, with clear linkages to the knowledge bases within nursing and social work. These two distinctive interpretative repertoires are identified as ways of talking about caregiving. Aspects of duty, obligation and the moral imperatives within informal care are also emphasised in the analysis. In a similar vein to previous analytic chapters, chapter six is concerned with the way that both informant and interviewer structure their accounts and manage their responses.

6.1 The notion of the good carer

Both policy makers and practitioners see community care as a positive development and in the best interests of the society (Finch and Groves 1980). However, a tension for community care practitioners seems to centre on the balance between maintaining an individual at home even when the care falls short of acceptable. This brings into focus the issues concerning the nature of “good” or even acceptable care. Without straying too far down the much trodden path of what is meant by quality, it is worthwhile noting its relative nature. What one individual may regard as high quality, another person may perceive to be of a low standard depending upon among other things, expectations and prior experience (Norman and Redfern 1993). An assessment of care as good or bad necessarily becomes a judgement on its desirability and suitability. In terms of care, Donabedian (1980) links the areas of technical ability with interpersonal skills. From this perspective good care is presented as a cluster of desirable characteristics that relate to technical and interpersonal proficiency. Within this context, a “good carer” becomes someone who achieves a standard of performance, which demonstrates an enduring competence in these areas.

However, this approach in a similar way to trait theory mentioned the previous chapters, implies that individuals engaged in “good” informal care are predisposed to the administration of good care. They are in a sense, assigned a particular identity, which is consistent through a range of situations. Their technical and interpersonal proficiency comes to be seen as core characteristics of their personality. The following accounts

focus on informants' evaluations of informal care. In describing "good" care, the informants are building the very nature of success in informal care and good care comes into being in the light of these evaluations. We see examples of evaluation in the following extracts.

Extract (45)

Interviewer: What makes a good carer do you think?

Informant DN3: [pause] We had this chap and his mum was looked after him. She was an example of great care. He was very demanding. He wouldn't go in a wheelchair he was in his bed all the time. That was choice. He was fastidious about how his pillows were. He needed fed, he needed drinks. He was very demanding with his mother but she was an excellent carer because it was always, "well it's up to * . We'll see what * wants to do". It was her house but she always gave him the space.

We see the informant in extract (45) recounting a situation, which to her exemplifies good caregiving. From the beginning of the account the cared for has been assigned the particular identity of being "very demanding" as a means of establishing the degree of adversity. As this was no "ordinary" patient, the caregiver was under considerable pressure. To emphasise the point we see that the patient "wouldn't go in a wheelchair" and with this statement we see the extent of the dependency and thus the level of caregiver involvement. Note that with the use of the word "wouldn't", the listener is able to conclude that the client was not prevented by disability from using a wheelchair. He

did not *choose* to maximize his independence and the result of this is an implied greater involvement of his mother. Hence the patient “needed fed, he needed drinks”.

In this account we also see the informant construct good care as that which allows choice and self-determination. As the patient cited in extract (45) is highly dependent upon those around him, there is a clear indication of depleted opportunity to make choices. However, the caregiver was sensitive to this and not only tolerated her son’s demands but instead, encouraged them. This implies understanding and self-sacrifice, again working to towards a confirmation of her identity as a good caregiver. This is suggestive of an understanding of good care as an attitude in which the desires of the cared for are put before the desires of the caregiver in the way that a parent would subordinate their needs for the demands of their children.

Moreover the informant uses the word “always”. The caregiver *always* deferred to the patient to maintain his choices and she *always* gave him space in what was her own house. We have seen in previous chapters the practice of using extreme case formulation maximise the value of an object being described (Promerantz 1986). By using extreme points such as “always”, the informant is able to add weight to the claim that the woman was an excellent carer. It is used to emphasise that she is almost pathologically predisposed in character towards her son’s self-determination.

Choice has of course become a dominant theme in health and social care and we can see that it has a distinct social history that has evolved from the early 1980s. Firstly the

introduction of *the nursing process* saw an attempt to reformulate nursing into a theory-based discipline, in line with others such as medicine and law. Nursing practice was seen to lack a rational basis and to be heavily reliant on traditional, ritualised interventions. As a contrast the nursing process was perceived to be more scientific for its advocacy for the use of care plans and models of nursing. In addition patient documentation, which had traditionally been held exclusively for and by nurses, was to be accessible for the first time to patients. Although choice was not specifically accommodated, such factors created conditions that were in some way favourable for the move away from the patient as the passive recipient of care, towards the concept of patient consultation.

Secondly the white paper *Caring for People* and the subsequent legislation the NHS and Community Care (Scotland) Act 1995 provided a framework, which gave the consumers of services a formally implied right to consultation and inclusion in their own assessment and care planning. Moreover, the Conservative election manifesto of 1992 developed the general philosophy further by suggesting that society needed a government that gave “the power to choose – to say for yourself what you want” (Conservative Central Office 1992). Choice has become an increasingly visible value in services provision and continues to gain momentum. Clearly a range of ideologies, politics being one, influences the values within care. The informant’s account in extract (45) portrays good care as care which does not just centre on providing a good standard of physical care as in feeding and washing. It is given sacrificially in order to up-hold the choices of the recipient of care.

The account of self-sacrifice was common among all informants with most making reference to good care as, “putting the needs of the client first”. Unsatisfactory care was commonly cited within a context of the carer putting their own needs before the recipient of care. See extract (46) as an example:

Extract (46)

Interviewer: Do you think there's such a thing as a good or a bad carer?

Informant SCM2: No I don't know. I suppose someone who would do something maliciously harmful. I mean a carer by definition would mean that someone had some sympathy and understanding and concern for the individual. I think that some carers will go the extra mile and will perhaps be overdoing what they physically should be doing and that's probably as dangerous. Someone who is perhaps more concerned with their own needs and is neglecting the person's care. I suppose if you're with someone who perhaps needs a lot of physical attention and perhaps that person is not capable or interested in doing that I wouldn't describe them as a carer,

In this account it is interesting to see the informant's response to the interviewer's question, “No I don't know”, which as we have seen is a hedge while a more detailed answer is formulated. Also within the context of the adjacency pairing it is a dispreferred response as we see that it is a denial and that it is followed with an explanation. Notice also that although the question asks the informant for her perspective on both good and bad care, that her immediate focus is on bad care with, “I suppose someone who do

something maliciously harmful". Caregivers by "definition" are described as having "sympathy", "understanding" and "concern". Here the version of caregiving being offered, centres on a general concern for the welfare of others to the point of danger. Notice also that the informant makes reference to need to give "physical attention" and that to leave physical care undone would be an act of omission or neglect and thus not worthy of the title *carer*.

The contrast between going the extra mile to care as opposed to putting one's own needs first is evident and is clearly grounded in selflessness. For Gilligan (1995) women, through the process of socialisation are initiated into an attitude of selflessness that manifests as a "caring ethic" which can either be visualised as a *feminine* ethic or a *feminist* ethic. The feminine ethic of care is an ethic, which is bound within obligation and self-sacrifice, lying within the realm of an imposed patriarchal social order. Within the feminine ethic women are bound both internally and externally to care without complaint "on pain of becoming a bad woman" (1995 pg. 342). It is from this conception of a dichotomous inner and outer or public and private self that the feminine ethic comes into focus as the means by which women are bound to unpaid labour. For Gilligan this has forced a separation or disconnection with women's "real" relational voices. The patriarchal social order depends upon the disconnection with their relational nature and necessarily presses women into regulating relationships by limiting them to those that maintain the needs of men. Women therefore begin to disconnect from their relational voices in adolescence and come to live within the structure of the patriarchy.

The feminist ethic thus concerns the acknowledgement of a “discourse of relationships” which is not stifled at critical developmental periods and emphasises the need for women to think more broadly about their connections with others. Although Gilligan’s influence is clearly Freudian, she suggests that the mention of self-sacrifice hints at a faulty notion of relationship and one that implies a patriarchal construction of care. In other words, if women are bound to care through obligation and the need towards selflessness then they are “doing good and feeling bad” (Miller 1976). The self-sacrifice accounting suggests that there is merit in silence. To silence oneself is to numb oneself. One therefore has to subjugate one’s own feelings or else face the threat of becoming “a bad woman”. The following extract (47) provides a pertinent example of the caring ethic and its relationship to guilt.

Extract (47)

Interviewer: Do you think carers sometimes do too much?

Informant SCM3: Yes I think there’s often the pressure of the guilt is there. That you feel that it’s your mother and you just have to do this so you take them to live with you. What will people think if you [pause] and they don’t stop to think how are they gonna cope with that, what the management of that is and that’s when situations get into crisis.

In extract (47) the informant gives a “for example” type of account, which involves the relaying of a possible perspective on feeling guilty. Notice the use of the word “you” several times within this stretch of talk. “you feel that it’s your mother”, “you just have

to”, “you take them to live with you”, “what will people think of you”. The informant in this extract is as Goffman (1981) suggests, “changing hats” in that their role has changed. Although the informant as the social care manager is doing the talking, she is merely providing the voice for another person and is in a sense, speaking for someone else and in someone else’s words. Although she is using the personal pronoun “you”, the words are not about her. Instead she is describing a character who belongs to the world of informal care. Goffman contends that traditional notions of the speaker and listener are too simplistic and do not adequately represent the possible roles that a speaker may take within an account. In the case of extract (47) the informant is acting as the animator of the words. She is voicing what the informal caregiver thinks. Thus the words take the authority of the world of the informal carer and are made more “real”. As Potter (1996 pg: 143) contends the animator is “just passing something on” and by maintaining this position are able to distance themselves from what is said.

To return to the theme of the account, we have seen that the informant discusses the issue of guilt at not doing one’s duty. This is interesting as research conducted by Ungerson (1987) purported the idea that the word “duty” is absent from male informal caregivers vocabulary, men choosing to describe their involvement for reasons to do with love. As evident from research and commentary reviewed so far, it is notable that many women become entangled in caregiving that extends beyond spousal relationships and encompasses parents, in-laws and friends. Men on the other hand are more likely to care for a wife and to have minimal informal in put in the care of others. Therefore, for Ungerson it is love that binds men to informal care and not duty or obligation. Men are

not under any obligation to care, but for women obligation forms the hub of their experience. The following extract of text provides further evidence of this assumption.

Extract (48)

Interviewer: Research has been done in the area of the gender of carers and while more men are involved it still is largely women. Why do you think that is?

Informant SCM 2: Yes. I think more women feel a sense of responsibility em I would say it's because we for example are more diligent when it comes to providing support to a male carer. I think in relation to this the majority of people who are HIV positive are male and this means that if they are in a relationship or in a family the carers tend to be women. Certainly in my experience of the carers support group I think there are two men that come along but the rest are always women and it's predominantly mothers of the HIV positive em I'm trying to think of the number of male carers. From the women that are HIV positive tend to be single.

Again the theme of duty is evident in terms of, "women feel a sense of responsibility". However, there is a notable difference in the account in extract (48) when the informant offers an alternative perspective of service providers reacting more favourably to male caregivers, by increasing the levels of support. By virtue of the epidemiological profile of HIV more women than men become informal caregivers. The few male carers that there are, warrant their treatment as special cases. We can see the risk in terms of damage to the informant's social and professional identity in offering up the possibility of having a

hand in women's subjugation. However, notice the use of the word "we", which while implicating herself as part of the problem, brings in other players, that is other social care managers, serving to spread and thus dilute the blame.

The concept of linguistic devices orientated towards preserving professional or social identity has been previously discussed in relation to the techniques deployed as a way of avoiding giving potentially difficult answers. However, interviewers questions can also be orientated towards protecting the informant's social and professional identity in as much as they are structured to be less troublesome to the interviewee. By focusing on the sequence in extract (48) we see that the interviewer solicits the views of the informant as to why more women than men are involved in caregiving, with a statement linked to research. The interest here concerns why the question has been formulated in this way and on this point it is pertinent to turn to the work of Goffman (1967; 1979) and more recently Clayman (1992). Goffman highlighted that speakers change "footing", which essentially involves switching between different roles as speaker, as a means of managing accountability. Thus the speaker may in some circumstances attempt to bring a neutrality to the interaction, particularly if an utterance may be interpreted by the participants as contentious and therefore a potential threat to social or professional identity.

Clayman researched this and demonstrated how speakers, instead of challenging or confronting a participant, are more inclined to produce an utterance which shifts the footing in such a way as to allow each participant to carry off their chosen role.

Clayman's work has centred on how neutrality is managed within interactions and we

can see that interviewers' questions that are perhaps confrontational may be harmful to both participants' identity. This brings us back to the text of extract (48) where we see that the interviewer is alert to the potential difficulties that may arise from a closed and possibly threatening question. Therefore by setting the question with a context of already established knowledge, "research has been done" or "according to the research", makes the question less contestable, less threatening and less open to alternative interpretations. Indeed for Clayman (1992) a shift in footing tends to appear in interaction where contentious factual claims are made.

Therefore individuals must manage the interaction in such a way as to protect the social value of all concerned or else risk a negative attribution. A further important aspect to this of course is that we are not concerned with the issue of whether the question is "in fact" contentious. The issue lies in the way that the individuals engaged in the interaction treat the question and indeed by treating the interaction as controversial they are also constituting thus.

6.2 In sickness and in health

The theme of sacrificial care can appear in various forms of accounting. According to Oliver (1983 pg.75) most people when they say the marriage vows "for better and for worse" and "in sickness and in health" expect that it will turn out to mean, "the odd bout of flu". Few people imagine that they will become involved in the kind of all consuming care that is sometimes required and this clearly has implications for how individual

couples respond to these demands. Many of the informants did draw on accounts featuring marital obligations when asked to recall examples of good or bad care that they had seen. One in particular made direct reference to the marriage vows in this short extract taken from a very long stretch.

Extract (49)

Informant DN1: and I mean you take the vows, “in sickness and in health”.

Oliver suggests that many professionals in health and social care work on the assumption that “the ability to cope is bestowed with the wedding ring” (1983 pg.73). For Oliver marriage is therefore considered by many to be an alchemic ceremony, which transforms and endows. Marriage, as both a social institution and an emotional relationship implies a contractual and moral obligation to care. Certainly research suggests that this is the case for men, with men’s caregiving involvement centring the care of the spouse. To adapt a phrase suggested by Doherty, Kouneski and Erickson (1998), it seems that women are caregivers all their life, while men are caregivers if they have a wife.

However, complexity arises when there is some difficulty in the marital relationship and the ability to cope is tested. The following of text says something of this complexity in relation to the fulfilment of the moral precept to care.

Extract (50)

Interviewer: Have you ever been involved with anything that you thought was bad care?

Informant SCM2: I think one time that springs to mind is certainly a woman who's relationship with her husband was very poor in fact they'd separated and when she found out how ill he was she allowed him to return to the home and with hindsight I think it might have been better for both had that not happened but she clearly felt that she should, rather than she actually wanted to care for this person. He was the father of her children and I think she clearly felt that em she should be providing care but she clearly didn't. She went to work. Other people where going in and out trying to support this man in the family home.

The informant in extract (50) above has recalled a situation where a married couple had separated for unspecified reasons and because of the seriousness of his condition, the male partner had been allowed to return to the family home. Despite an obvious antipathy, the caregiver felt that "she should" be involved, the imperative clearly being a sense of duty. Although the couple had separated, the obvious thrust of the account concerns marital obligation. However, the explanation implies that the obligation merely extended to providing a roof over the patient's head. The caregiver as such is constructed as not delivering care and the major task of this account is to provide evidence to support the representation. The account provides one particular comment to this effect. We see that, "she went to work. Other people were going in and out trying to support this man in the family home", leaving the care instead to paid carers. Although the account offers very little in the way of contextual detail the constructive work is nevertheless performed

in this single utterance of, “she went to work” and the caregiver takes on a negative identity. In addition it is not difficult to picture a host of service providers “going in and out” and therefore very busily employed in providing care, leaving an impression of services being over-stretched because of the woman’s failure. Indeed it is difficult not to read this extract without hearing a moral judgement. Twigg and Atkin (1994) comment that formal service providers share a common idea of marriage and families and that this has a tendency to underwrite how they view responsibilities. The carer is not described as having abused or mistreated the patient. She did not carry out her obligation to care, the caring was left to others. This, in itself sufficiently portrays her as a “bad carer”.

A further feature of this extract is the constructional work in the utterance, “the family home” and we must ask why is this here? It is clear that its presence shows further orientation towards the failure of the caregiver. This works to emphasise identity of the individuals concerned in that they still were a family and with that comes a duty of care. Moreover it was as much the patient’s home as the informal caregiver and yet his needs were neglected.

Conversely we see in the next extract (51), which follows on from a stretch of talk featured in extract (17), an account of informal care where the judgement appears to work in the caregiver’s favour. It is part of a longer extract in response to a question concerning examples of good care. Another marriage in this stretch is portrayed as troublesome and yet the quality of the marriage was not presented as a barrier to caregiving. The husband, the patient is terminally ill and is cared for by his wife.

Extract (51)

Informant DN1: I mean I didn't realise until latterly that he wasn't [pause] years ago he wasn't a particularly great [pause] well he was a good husband but he didn'tI think she's had bad times with him. I think he drank quite a lot and em I was unaware of that. I could observe that life wasn't easy but she did marvellously well. In fact she'd had had coronary artery bypass surgery.

A number of issues arise from this account. The informant sets out initially to describe the male character, the recipient of care, in an unfavourable light but then engages in self initiated repair by changing the emphasis to something generally more positive. He is eventually described as a "good husband", and although his virtuous or desirable qualities are unspecified it is worth pondering what the informant might mean. Wetherell (2001) asserts that when considering the meaning of an utterance the reader should examine the immediate context of what has been said. With this assertion in mind it is clear that what precedes the utterance is that he "wasn't particularly great" and what follows is that she "had bad times with him", and "he drank quite a lot". The positive evaluation is therefore coloured by the negative references.

What then is the normative construction of a good husband and how does that contrast with one that is bad? To be described as a good husband is to be associated with a particular symbolic status that is contingent upon conventional gender identities. This brings us back to the practices and characteristics of both marriage and masculinity.

Conventional western versions of masculinity such as that offered by Parsons and Bales (1955) represent men as being best suited to paid work outside the home. Therefore constituent elements of being a man within these confines concern the ability to provide for the family through the sale of labour (Edley 2001). Perhaps the informant is drawing upon the culturally agreed association for a “good husband” which signifies that he fulfilled at least some elements of his symbolic status, the *good provider* or the *bread winner*. In research conducted by Wilson (1987) men were typically evaluated as being good or bad providers by their wives, particularly in relation to lower income families. In addition lower income men could be good providers but they were not expected to be good managers. To work and bring home a wage is perhaps the constitutive elements of being a “good husband”.

Furthermore, this extract as such is made to perform ideological work in that as with extract (50) analysed previously, it produces a version of social reality in which caregiving is constructed as a moral duty. The informant has been asked to recount an example of good informal care and chooses one in which caregiver’s personal interests are transcended by duty. The marital difficulties encountered by the caregiver are apparently no barrier to the fulfillment of her caregiving role. Not only have relationship difficulties been set aside but the informal caregiver’s own health problems have been subordinated to the needs of the recipient of care. The carer has done what is right or moral.

In addition the informant is attentive to the idea that the version of events she is recounting may be heard in a number of ways. Looking at extract (51) again we can see the early introduction of a form of stake inoculation with “I mean I didn’t realise until latterly that he wasn’t...” and, “I could observe that life wasn’t easy ...”. The informant has produced a character in the caregiver who is virtuous and selfless. However, this version may be undermined if the informal caregiver appears to have told the informant about their marital difficulties. The informant needs to emphasise that the caregiver did not openly condemn her husband for past iniquities, as to do so would change the character of the caregiver. To present the information as something that was stumbled on accidentally or as suggested, merely observed, adds weight to the claim that the carer is indeed selfless and acted out of compassion and duty.

In extracts (49), (50) and (51) there is a clear link between caregiving and marital obligation. The marriage vows are enduring even in circumstances where the relationship is in difficulty or has floundered. Informal caregivers are expected to put any discord to one side in a patient’s hour of need and the descriptions of good and bad care are organized to make these inferences hard to resist. Morgan (1996) discusses the changes in family life and marriage from the 20th century, charting its movement from institution to relationship. However, extracts (50) and (51) are more centred in marriage as an institution. The relationships may be problematic but institutional obligations still remain. Of course it could be argued that talk of marital obligation while being “part of the commitment” could also be identified as a commitment to upholding the values of the patriarchy.

6.3 Good care as nursing

The evaluations on the success or otherwise of informal care also demonstrate an occupational orientation from both sample groups. The transcripts of the interviews with the district nurses emphasise the idea of good informal care as technical proficiency. The accounts also mirror the concern that care within the home is becoming increasingly more complex. A range of procedures are now administered and maintained in a non-clinical environment with minimal supervision by qualified staff as a result of the pressures within the institutional environment of the NHS. The pressures are reported with reference to long waiting lists and beds blocked by patients who are unable to be discharged either to their home or into institutional care settings. Consumer choice perhaps also works as a hastening factor, opening up the possibility for early discharge, in so far as individuals would be understandably motivated to return home rather than remain in hospital. The emergence of new conceptions such as “Early Hospital Discharge” teams and “Hospital at Home” schemes evidence a compulsion towards the movement of acute care away from the acute environment of the hospital and into the home.

The resulting issues stemming from non-admission to hospital or early discharge are then that technical nursing activities such as tube feeding and the intravenous delivery of medicines are routinely administered procedures in the home setting. While it is not suggested that clients and their families are insufficiently supported it is clear such

activities place an onus and a level of responsibility on informal caregivers. Some will be willing and able to contribute. Others may do so with a degree of reluctance. Indeed research previously reviewed (Bauld et al 2000) found that the most common area of unease for informal caregivers was the delivery of medical care such as changing catheters and bandages. Symonds and Kelly (1998) see such developments as examples of something akin to post-Fordist patterns of work organization. Movements towards “skill-mix” means that a core of highly trained staff is retained to guide less qualified assistants as a means of producing a flexible work force. With the development of “Hospital at Home” schemes the informal caregiver becomes the less proficient assistant. This aside, the movement towards clinical nursing in the home creates the potential for difficulty with regard to the criteria for success in informal care. If the technical expectation of informal care escalates, what does this mean for the caregivers who are unable to offer such a standard? The following extract, featured in Chapter Four demonstrates how good informal care is constructed as mimicking nursing.

Extract (17)

Interviewer: You must see cases where you would consider to be good care.

Informant DN1: There was one. A patient just died there. He was a man with oesophageal cancer. He had a tracheostomy. He had a peg tube you know and his wife was excellent with him, you know, em, she hated the nurses helping him. Em you know she used to sort of help him to wash and you know put his uridome on, put his uridome off, connected up his food, em you know, put the medication down his peg tube, you know. She would change the trachistomy tube, you know

if it got blocked she knew how to change it, em, you know she was like did everything really that he needed around him. She slept in the same room in the bed next to him and you know was concerned about his skin. I mean she as excellent, she really, really was. You could tell you know, just going into the house you could just tell that you know she cared for him

Extract (17) places care within the context of nursing with its emphasis on quasi-medical activities. The informant is using a variety of nursing terms to provide evidence for her description of the care given as being very good or “excellent”. The repertoire is organised around activities such as changing the incontinence device, feeding and administration of medicines through the gastric tube, changing the trachostomy tube as well as maintenance of the skin. These activities are traditionally to be found within the institutional context, but more latterly they are performed within the home environment in line with the changing paradigms of health care delivery. For the informant, good care is constructed in a way that makes it heavily dependent upon the proficient administration of nursing procedures. It is important also to note the way that the informant lists the activities that the caregiver undertook, providing several examples to emphasise the extent of the caregiver’s worthiness as an example a of good carer.

A further feature of the account is how the informant manages the description of a good carer by alluding to the now familiar repertoire of care giving as sacrificial. We note from the extract that the caregiver “hated” the nurses helping her husband and that she

continued to sleep in the same bed, leaving the reader with the impression of disturbed sleep. We see this theme repeated again in the following extract:

Extract (52)

Interviewer: Can you give me any examples of where you thought the care was especially good?

Informant DN3: Just thinking. The carer's given you know as much as they could at the time. You know they've lifted on and off the commode, they've washed them and fed them and changed them.

In the above extract (53) we can see the usual form of adjacency pairing. The interviewer's question asks for examples of especially good care and the informant responds with "just thinking", a hedge to buy time while she formulates a satisfactory response. The account eventually offered is not specific to an individual case and refers to a general class of caregivers who, give "as much as they could at the time". Again this implies a construction of caregiving as a sacrificial activity and as we have seen this is a common reference point. We see also that as with extract (52) good care is described in terms of an occupational standard within nursing. The caregiver is physically attentive to the recipient of care, performing a range of "hands-on" procedures, such as lifting a patient "on and off the commode", washing and feeding them. Note also the listing of the activities in common with extract (17). Extract (53) below draws from the same repertoire.

Extract (53)

Interviewer: What about good carers. Do you have any examples?

Informant DN 2: One case that springs to mind that we had last year. A husband and wife and the husband had cancer and he came home to die and she was the absolute model carer. She just did everything you told her to just just listened to you. She cleaned his mouth out two hourly on the dot. She knew about checking his heels. The bed was just perfectly made. She gave him sips of water so frequently and drinks. She was just [pause] the medication, she had everything down. I mean you never meet anything like that she was just the best carer I've ever met in my life. She was great she was very open to communicating. She was very keen, very anxious to do everything right.

In extract (53) the informant responds to the interviewer's question by casting her mind back to a specific situation indicating verbally that the information is not readily at hand. She recalls a patient's wife who was an "absolute model carer", and described as such becomes an idealized version of a caregiver, exemplifying all that can be expected. To substantiate this status and support the assertion, the informant lists a range of authentic nursing activities. We see as well as carrying these out the caregiver, "did everything you told her to". Therefore we have a caregiver represented as a willing participant, technically proficient and subordinate to the "expert" formal service provider.

The caregiver is said to have “cleaned his mouth out two hourly on the dot” and this raises the question of what is implied by the reference to timing in this way? There is a clear indication of timing as an important issue. Not only is a two hourly routine maintained but the caregiver did not adopt a *laissez faire* approach. The procedure was carried out with precise timing, “on the dot”. What is happening here is that the informant is emphasising that the nursing procedures were not carried out on an *ad hoc* basis but were timetabled events. As Chinn & Jacobs (1987) suggest, ritualised practices have a long-standing tradition in nursing and are thought to have occurred as a result of the training of nurses rather than their education. Historically nurses, they argue have been trained through the apprenticeship system and as such are trained merely to observe what goes on and copy the way things are done. They have not been equipped to consider alternatives to ritualised practices and indeed rituals have been borne out of a need to standardise procedures as a means of limiting initiative.

Weber’s (1978) view of bureaucracy suggests that the more bureaucratized an organisation the more tasks are fixed and detailed. It is not difficult to draw comparisons within the health service and the range of activities that have been ordered as timetabled events, spanning the administration of medication to positional changes. The informant’s account of good care brings in the timetable to validate the care as an authentic nursing activity. To refer to it in this way is to use the bureaucracy of institutional health care systems as a frame of reference and thus bring an authenticity to the caregiver actions.

6.4 Good care as insight and authentic knowledge

The previous section focused on good care as a mimicry of nursing activities and used utterances from health care practitioners to demonstrate the use of nursing activities as a frame of reference for informants' descriptions. As noted, many of the accounts draw on the relevant professional remit as a resource with which to characterise informal care.

The social care managers also used an occupational frame of reference in their evaluations. See for example the long stretch of talk in extract (54):

Extract (54)

Interviewer: What about qualities of informal carers? What qualities do you think they should have?

Informant SCM1: Patience, that's a big one especially if someone has a degree of dementia and is constantly repeating themselves or getting up during the night.

Obviously it helps someone is they are able to express [pause] if they've got some insight into their situation and their own situation and how they're interacting with the person they're looking after. If they have insight into that they're able to articulate. I mean some people can say "right this is happening could you do this, this and this." It's basically if you sat down and assessed the situation it's the conclusion you would have come to as the best means of going forward. And they come out with "how about this, this and this". Obviously they're the easy ones. Emm you tend to find the people in that situation tend not to get the situation out of control. It's maybe people don't have the insight and

don't take a step back `and maybe not able to articulate their needs. That's when the situation tends to blow up, a pressure cooker effect. It falls to bits and you're kind of set back a bit picking up the pieces.

Interviewer: And you want to avoid the crisis?

Informant SCM1: Yes, yes that's part of the job you want to get in there and prevent that from happening. Again some carers are easier than others. Again if the person has the ability, has the insight to articulate it certainly helps. It helps you to do your job. Em caring, empathetic.

The account begins with a reference to the demands of caring and draws on the example of dementia. As we have seen in previous analysis, dementia as an illness is a useful category to refer to as it implies an extreme range of behaviours, which are now part of a conventional stock of knowledge. We see from the account that informal carergivers should ideally have a degree of insight, which will enable them to identify their own needs, that is, when the demands of caregiving are beyond their personal capacity. This insight can also extend to identifying the needs of the recipient of care. It implies that social care managers have little time to investigate problems and search for answers. If individuals can articulate what they want, then crises can be avoided. Situations don't get out of hand, thus avoiding more intensive and time-consuming measures that may be required to alleviate the problem. We see that if the caregiver does not articulate their needs, then the situation deteriorates and "It falls to bits and you're kind of set back a bit picking up the pieces". More work is created, making the job of the care manager all the more difficult.

The “easy ones” are the caregivers who operate at a level of insight similar to that of the professional social worker, “It’s basically if you sat down and assessed the situation it’s the conclusion you would have come to as the best means of going forward”. It is clear that this informant, like the district nurses is producing a version of informal care in line with his own professional context. In addition it is notable that the account differs from the nurses account in that it makes no reference to the day-to-day, hands on story of care. It is not an activity or task based account and no mention is made of personal or physical care, again perhaps because community care practitioners make sense of informal care in the light of their own professional remit. We see reference to this again in the following text.

Extract (55)

Interviewer: What is good care? Can you give me any examples?

Informant SCM1: Em it was one instance where it was a daughter caring for her father, he had dementia. She didn’t live with him but lived nearby him. This situation, he was actually fairly young, late sixties early seventies. The dementia, his mental state deteriorated very quickly, emm but again she knew quite a bit. Before I was involved she actually had been to various support groups, she’d been to Alzheimer’s Scotland. She’s read up, she knew pretty much all there was to know about the various types of dementia, the symptoms so again she kind of just stayed in touch and just kind of run things past me to see how I felt.

In this account we see again the dementia narrative. We see also a number of other details that are not immediately relevant to the narrative. We are told of the geographical proximity of the carer to the recipient of care, as well as the age of the patient. It is precisely these kinds of mundane details which speakers regularly mention as a means of building up facticity in accounts. We know from previous analysis that accounts are often treated as motivated and that one of the methods of protecting against this problem is to structure it in a way that makes it resistant to undermining. By referring to apparently inconsequential details, such as age and proximity, the speaker is of course adding detail. Alternatively we could see this as “putting flesh on the bones” and as such turns the situation described into something much more “real”. Detail in an account works to build the object being described into something factual.

Returning to the issue of the theme of the account, the informant in extract (56) presents a picture of good informal care as a carer who is proactive and is orientated to the care of the client in a pseudo-professional role. This is in line with Kelly (1998) who suggests that the role of the social worker has become increasingly administrative as a result of the emphasis on the “mixed economy of care”. In addition the account has similarities with that of the district nurses in that it implies a degree of proficiency. The caregiver has “read up” and had “been to Alzheimer’s Scotland” so she was therefore the possessor of some authentic knowledge. In addition it is also clear that the account emphasises the hierarchical structure with the utterance “just kind of run things past me to see how I felt”, indicating an element of professional power in the relationship.

In extract (56) below the informant draws heavily on the notion of insight as an integral feature of good care.

Extract (56)

Interviewer: What about the qualities of caregivers?

Informant SCM3: What should they have? I think just just quite open. I think from my point of view, from our point of view I think if they're quite open and tell us what they feel but I think if they're open, tell us exactly what they feel which is hard for people but if they're open, if they're able to tell us what's happening. How the situation is and how stressed and how they do feel, what they really are able to do and what they just can't do and how they see things going. That really helps.

In extract (56) we see the familiar question and answer sequence but note that the informant seeks clarity on the meaning of what is being asked. What is presented as a response is a list of attributes, which are eventually characterised by “openness”. In this sense, good informal caregivers do not conceal their thoughts and feelings and do not make a pretence of coping, when in reality they may be experiencing difficulties. They are prepared to “tell it how it is”, thus reducing the potential for the service provider to read the situation incorrectly. There is an acknowledgement that such openness may be “hard for people”. Again this form of account hints at the importance of insight, in that caregivers should ideally know from the outset their own personal limitations in order to

prevent difficulties occurring at a later stage. That there is an element of “misrepresentation” in that caregivers may suggest that they can do more than they are able. Alternatively this account features the expectation that informal caregivers should have foresight and should endeavour to predict how well they will fare.

Importantly although the question refers to the qualities that informal caregivers should ideally have, the account does not feature the normative aspects of caring. We see no mention of kindness, patience, tolerance, physical tending, sensitivity etc. Instead as we have seen, personal insight takes precedence. The informant continues with this theme in the extract (57) below:

Extract (57)

Informant SCM 3: For good qualities for a family member again its just openness and I suppose being able to say when enough is enough and to be interested enough to take part in meetings. To take an interest in the patient, to find out what’s going on for them and ideally to be able to seek assistance when they need it.

SCM3 repeats the issue of openness and of caregivers being able to say when things have got too much. However, note the importance of taking part in meetings, presumably case conferences. We see that they should be “interested enough” to engage in this activity. Twigg and Atkin (1994) have suggested that caregivers who are assertive are more likely to receive formal service provision, which better meets their need and the needs of the

recipient of care. Service providers, they comment tend not to seek out cases but respond to those that are most visible. Therefore they may actively encourage informal carers to adopt a more assertive stance to enable them to establish and maintain more appropriate help. The account in extract (57) clearly emphasizes openness and assertiveness as virtuous characteristics and necessarily implies that a lack of assertion is a sign of being disinterested. However, the degree to which caregivers are able to exercise these qualities is open to debate. As we have seen from previous sections, to provide care for a close family member is to operate within a context of normative expectations with regard to duty and obligation. Therefore to defend one's rights to service provision and to argue for more resources is to risk a negative evaluation.

The informant SCM3 continues the account in extract (58) below providing further evidence of the insight form of accounting and the issues discussed.

Extract (58)

Informant SCM 3: Good carers are again people who do the majority of the caring. They are people who able to identify things that are maybe working or not working and approach people about that. We carry quite high caseloads and we do review every so often but if I've got a care package in that seems to be working then I won't call every week. If there's people involved that have my number that have approached me in the past and if I'm quite certain they would if there was an issue. But good carers would call me.

We have seen that an emphasis has been placed on openness, assertiveness and the ability say when “enough is enough” in this informant’s previous accounts. This implies there is virtuousness in not being able manage. However, in this latest extract (58) it is suggested that good carers are “people who do the majority of caring”. It is clear on analysis that the points made do not sit comfortably together. On one hand good informal care is characterised by carers who readily admit to weakness by requesting an increase in support. On the other hand it is distinguished by doing the majority of the caring unaided. Clear evidence then of Billig’s concern with ideological dilemmas discussed earlier (Billig 1997). This stretch of talk gives an indication of the pseudo-professional insight theme. As social care managers cannot attend to every case as often as necessary because of pressures of a heavy caseload, informal caregivers ideally perform the role of the social care manager. They spot the problems, identify the root cause and refer on.

6.5 The Bureaucratized Carer

Current orthodoxy in health and social care emphasises partnership between service providers and the users of services and this is reflected in legislation, both in the NHS and Community Act (1990) and the Carers (Recognition and Services) Act (1995). At the policy level there is now recognition that service users as clients or carers should participate in decision-making about care that affects them. However, it is largely up to individual service providers as to whether they seek to engage service users in this process (Barnes & Walker 2000).

As detailed in earlier sections, research by Twigg and Atkin (1994) have suggested that service providers engage with informal caregivers in a number of ways namely as co-clients, co-workers and resources. In terms of the co-worker model of engagement the question of the degree of partnership comes to the fore, in that caregiving becomes a joint enterprise. However, the concept of a partnership implies joint ownership and equality but as Waerness (1987) points out, formally acquired knowledge is considered to be of greater value than knowledge acquired via informal or “lay” means. This presents as a something of a paradox within the context of the shifting balance of power in the spirit of the legislative changes. If informal caregivers have expertise in care, which has been attained through their social sphere, how then is that to be recognised by service providers? The following extract sheds some light on the difficulties.

Extract (59)

Interviewer: Do you think there is such a thing as good carers and bad carers?

Informant DN2: I wouldn't really say that there were bad carers.

Interviewer: How would you describe them?

InformantDN2: I think there are some carers who are less willing to hear what you have to say and to take the advice and there are some carers who don't believe what you have to say.

The informant is being asked a potentially threatening question which requires her to provide a judgement. This has to be managed carefully as a negative evaluation or criticism of informal caregivers could potentially threaten the informant's professional or personal status. Thus the informant's initial response is to reject any immediate

alignment to the idea that informal carers can be “bad”. The interviewer returns with a request for the informant to provide her own description. While she makes it clear that she would not really say that there were “bad” carers, the implication is that their failure to take up expert advice may cause hurt to the client. By implication the informant constructs the informal carer as the holder of a less authentic form of knowledge. They don’t want to take advice and more pointedly, they don’t believe the “expert”.

For Davies (2000) knowledge is something to be possessed as a means of bringing about control and order over those who do not possess authentic knowledge. Therefore the specialist as the possessor of superior knowledge has more power than the generalist. The NHS and Social Services are recognised as intensely bureaucratic organisations and for this reason they are strongly hierarchical in structure (Giddens 1989). Those with the greatest authority are at the top of the pyramid and are usually made up of individuals from a professional background (for in depth commentary see Freidson 1980). Nurses and social workers although recognised as professionals in the broadest sense, have little control of their conditions of work. Both parties are subordinate to those in the layers above and this influences how much autonomy they have. Therefore what happens in health and social care settings, is to a large extent dictated and regulated from the top down, with each higher office controlling the conduct of the one below.

Extract (59) above implies a hierarchical relationship in health care and naturally this brings into focus the paradoxes in the actual workings of equality and user

empowerment. The co-worker model indicated by Twigg and Atkin's research suggests the needs of the informal caregiver are partially recognized and that the aim is ultimately to provide the highest quality care for the recipient. Caring is seen in this model as a joint enterprise between informal and formal caregivers, which is necessarily suggestive of equality. However, it is clear that the informant is referring to a bureaucratized model, which places the informal caregiver, as the possessor of inferior knowledge, at a lower point in the hierarchy. See extract (60) below as a further example.

Extract (60)

Interviewer: What about at the other end of the spectrum in terms of good carers. Do you have any examples?

Informant DN 2: One case that springs to mind that we had last year. A husband and wife and the husband had cancer and he came home to die and she was the absolute model carer. She just did everything you told her to just just listened to you.

We have seen this extract before in a previous section and the informant is replying to the question concerning good carergivers. The example offered is suggestive of someone who will readily recognise their place in the hierarchy as the possessor of an inferior knowledge. The carer is constructed in this case as an apprentice or learner, a reflection of the traditions within nurse training. We see that the caregiver, "did everything you told her to" and that she, "just listened". Therefore within these confines

the “model” informal caregiver is expected to acknowledge their deficits, react with gratitude and soak up the technical knowledge that is offered to them. Sundin-Huard (2001) comments on the traditional discourse of the “good nurse” as a particular subject position. A “good nurse nurtures, supports, listens, helps and is obedient” (Sundin-Huard 2001 pg: 378). We see evidence of this again in the extract (61) below:

Extract (61)

Interviewer: Can you give me an example of where you thought the care was bad?

Informant SCM5: I’ve given you an example of a bad carer. He wasn’t prepared to or didn’t know how to listen. He couldn’t comprehend that his wife was so vulnerable and the physio and nurse just trying to enlighten him and show him the way to move her from the chair to standing position. He would go from one extreme to the other saying, “I know she can do it I’ve seen her walking up and down that lobby”, and we’d say “look” and you can see her sitting busting out crying and we’d try to make him see and he’d say “yes that’s it, it’s me, me again, I’m wrong.” Of course it was the guilt. He was unable to comprehend the depths of his wife’s needs. He didn’t think she was as disabled as she made out.

The interviewer’s question in extract (61) is answered with a preferred response. The informant returns to the example of the inadequate care offered by a male caregiver, as discussed in the previous chapter. In the same way as extracts (59) and (60) this formulation features the implied ideal of good informal care as listening and accepting

the advice offered by legitimate practitioners. Bad care then is constructed as a refusal to shift caregiving strategies despite the advice of experts. The problem lying at the heart these accounts is most certainly, ignorance. Notice that in extract (61) the combined efforts of the speaker, the physiotherapist and the nurse to “enlighten” the caregiver, failed to convince him of their expertise. Simple practically based opinions to guide actions, such as moving the patient were areas of contention, demonstrating the extent of the difficulties. We see also the degree of the caregiver’s irrationality, going from “one extreme to the other”. Not only does the caregiver refuse to listen but denies the evidence of his own eyes when faced by this is to mockingly take the blame.

The informant in extract (61) is offering an account that is rhetorically organised to build up a particular version of bad care. It features a number of conversational structures, which allows the construction to hang together. For example the account is furnished with detail and examples to support the evaluations. We see an example of the refusal to listen when practical advice is offered. We see evidence of the caregiver operating on extremes and proof of the distress that this caused to his wife. The mocking attitude gives further indication of the caregiver’s ignorance. Moreover the listener does not have to rely on the sole testimony of the informant, the physiotherapist and the nurse substantiate the account. So we see that the account has been designed to persuade the listener of its truth.

Again the informant in extract (62) below seems uncomfortable with the idea that carers could be referred to as “good” which would necessarily imply that some were bad.

Instead the informant locates the issue within the context of *good* as a depth of knowledge and *bad* as a lack of knowledge.

Extract (62)

Interviewer: Do you think there's such a thing as good carers?

Informant DN4: Good carers.... I think some people have a better understanding. I don't know whether I could term it as good. I think that would be a misnomer. I wouldn't like to say but some people have a better understanding and because of that they're happy to follow any instructions. Some people I think don't understand and the end result is not as good, the care.

We see that good equates with a, "better understanding" which has common ground with the *insight* form of accounting. However, the informant's description is developed to make understanding precursory to following instructions. With understanding, informal caregivers are "happy to follow" any instructions. If understanding is the key to good care, then what exactly needs to be understood? Within the *bureaucratized carer* form of accounting a hierarchical relationship is constructed between paid and unpaid caregivers. Perhaps what lies at the centre of this is the need for informal caregivers to understand the primacy of professional knowledge. If there is a lack of understanding in this area then informal caregivers may question the instructions of the professional and thus threaten compliance.

This form of accounting used by the district nurses contrasts with that of the social care managers who tended to draw on what could be described as more egalitarian account, which seems to emphasise a working partnership. See below:

Extract (63)

Interviewer: You've mentioned informal caregivers, do you think of them as co-workers or co-clients?

Informant SCM1: That depends on the carer. Totally depends on the carer. There are some carers where you end up having more contact with the carer and you probably end up speaking more about the carer and issues with their own life and it's quite often there can be issues related to the care of your client so em they're basically getting a social worker by the back door I suppose em and that ranges right through them to the other end of the spectrum where you have carers who basically have got their own lives sorted out and the social work input is to help them care for the person they're caring for. They're very up to date with the latest goings on, on what ever illness the person has that they're caring for and you know they feed back all the information which lets me, the care manager know em how `the situation is progressing and yet a lot of the conversations you're having with them it's like maybe having a social care officer or speaking to someone from Day Care, the feedback that you're having back and you're getting quality objective information on the person and how they're progressing. Yeah they're more co-workers than co-clients.

Extract (63) is interesting from a number of perspectives. Firstly it brings into focus the nature of the client in community care. If the practitioners of community care are to provide holistic care and thus consider the client in their setting, who then is the client? Indeed there is a persuasive argument to include all of the players in the recipient of care's social setting. Certainly the Carers (Recognition of Services) Act 1995 supports the notion that caregivers themselves have needs, which practitioners must address. In extract (63) the informant highlights that caregivers may have support needs which outweigh the support required by the recipient of care. Some caregivers then are co-workers. They are, "up to date" having a contemporary knowledge base and can be trusted to relate information on the true status of the client. Others, however, are co-clients and get the social worker via, "the back door". Of course this latter construction also hints at the idea of the social worker as a desirable commodity for those with "issues in their own life". Whether this relates to the social worker as a listening ear or as a practical help is open to debate.

Extract (64)

Interviewer: Do you think of carers as co-clients or co-workers?

Informant SCM 3: I think it just depends. I think it can be both. I've been in situations where it's definitely been a co-worker but I think you have to be aware that you're the one who's getting paid to do the job and as long as you bear that in mind. But certainly there are people who are able to make the calls to get things in place to do that for their families. Then that's fine if they're coping with that. You know social workers enable people to do things that they can do for themselves.

I'm not here to take away these responsibilities, I'm here to help and if there are bits they can do or for whatever reason they're not allowed to access then I can do those but certainly if carers are able to do things and they're coping with it then there's no reason why they shouldn't do it, I'm not here to take that way from them.

In extract (64) the informant is working up a definition of social work as a job of coordination, making "the calls to get things in place". Social care managers do not provide physical care, they do a job of coordination. As the informant comments, they "enable people to do things that they can do for themselves". There is a clear orientation here to the idea of the caregiver as a co-worker. However, closer inspection reveals that despite this orientation the talk is also peppered with issues, which construe the relationship in a different way. Any talk of co-workership must be measured against talk of ensuring that people meet their responsibilities. This form of accounting gives an alternative version of the co-worker talk and necessarily implies a type of working which like the district nurses accounts, is based on a hierarchical relationship. The social care managers within this context are overseers of the family, ensuring that members meet their obligations. The accounts are orientated towards an ideology of individualism which as Crawford (1977) suggests is characterised by an emphasis on "self-responsibility, self-reliance and self-discipline". This kind of talk allows informants to present themselves as supporting the notion of equality and partnership but it also affirms themselves as the controlling agents and at the same time encourages individual responsibility.

6.6 Informal care as personal responsibility

The following stretch of talk in extract (65) again draws from the *bureaucratised carer* account but also has a number of other important aspects worthy of analysis.

Extract (65)

Interviewer: Can you give me an example of where you've been involved with a good carer?

Informant SCM3: I.... one of my very first clients.... service user was a woman in her late eighties who had mild dementia and she was attending the day hospital but was determined to stay at home em her daughters lived in Canada and the South of England so they weren't really able but I had good phone conversations with them and she had a niece locally and I felt that she was very good with her. She was clear with me about what she saw her role as. What formal time she would be able to visit and if there was a problem with that then she would let me know. She responded to emergencies very well and she was quite keen to attend any service reviews of what was going on, to discuss any changes we would consult her and she was quite happy for that and was interested in her aunt's condition and was able to take that on. She again was holding down a fulltime job and had family commitments and had really thought about what she could do. I think she was really good because she did care. You could tell she cared but she was also very realistic about what she could cope with an also responded to

emergency situations and saw that it wasn't just us that was responsible, we all had a responsibility. I think it worked quite well because she had trust in me and I had trust in her and we worked quite well together and we sustained that lady in her own home for a long time.

The informant is recalling a situation that provides an example of good practice in informal care and brings to mind a caregiver that was representative of this group. The extract follows a narrative style, commencing with a preferred response and providing a little background. We are told of the diagnosis and condition of the client and of the complicated family situation. Because of the geographical distance between the client and her daughters, it is the client's niece that is the informal caregiver. We have been introduced to the concept of the hierarchy of caregiving in previous sections and have seen that informal caregiving tends to follow female lineage, starting with the spouse in the case of married couples, followed by the daughter and daughter-in-law and then other female relatives (Qureshi and Walker 1988). While we do not know whether the client had a son in the local area it is still no surprise that it is a female relative who has been co-opted to provide informal care. However, the normative expectations for a niece to be involved in informal caregiving is clearly not as strong as for a daughter. Therefore because of her position in the hierarchy the niece could be justified in refusing or in negotiating a reduced input. The expectations are somewhat diluted within this context. Nevertheless we see that level of care given is substantial. For example the niece "attended service reviews", visited her aunt and maintained regular contact with the care

manager, as well as responding to emergencies when required. At the same time she was able to maintain family life and a full time job.

What is happening in this account is that the informant is bringing off a version of caregiving, which emphasizes individual responsibility. We see that the niece provided a substantial level of support to her aunt despite having other commitments, which could justifiably nullify any claims that could be made on her. These commitments together with her position in the hierarchy were not mooted as barriers to involvement when they could have been. The informal caregiver took her responsibilities seriously and did not attempt to escape them. Good care is being brought into being as a particular entity through drawing on the concept of responsibility. While such a construction fits neatly within the co-worker model of care we see also that it is meeting the ideological requirements for the successful working of community care.

As with the previous extracts in this section the informant builds a picture of good care which emphasises at one level the co-worker repertoire. However, it is also evident that accounts that describe informal care in this way also work to position it both against the ideological standard and the standard of formally provided care. Billig (1997) drawing from the work of Volosinov, discusses the idea that language has an ideological history, meaning that speakers use utterances which are rooted in terms that are available from historical, cultural and ideological resources. For Billig ideology becomes the commonsense of a society, a way of thinking and behaving. Habits that are perceived as commonsense are justifiable on the basis that they are natural and therefore inevitable.

The concern for “responsibility” in extracts (64) and (65) finds its ideological roots in early community care policy (detailed in chapter one) that represented a move towards encouraging a familial model of care as a means of reducing state burden. Responsibility has become a theme, which is rooted into the consciousness of society through language.

In these accounts the speakers are making ideological utterances, which are passed off as commonsense. We see from the statement in extract (65), “You could tell she cared but she was also very realistic about what she could cope with and also responded to emergency situations and *saw that it wasn't just us that was responsible, we all had a responsibility*” that the informant is constructing a consensus. The niece’s apparent collusion works to create a consensus, which affirms its status as a commonsense value. Shared responsibility and therefore less reliance on the state becomes habitual and thus natural. Such utterances work not just at the ideological level but also at a practical level, by producing willing “pairs of hands” who will augment existing formal services not only reducing costs to the state, moreover enabling greater flexibility for service providers at a local level. We see this theme again in the following extract (66).

Extract (66)

Interviewer: Do you think that’s an increasing issue? Carers being asked to take on a lot more responsibility.

Informant SCM3: Yes I think there’s certainly a lot of added pressure. There’s a lot more people out there needing higher levels of care and money and services are always the problem. I think, I also think that personally, although this might

be quite controversial, there was a time when we took everything away from carers, we took everything away from the community and we said “well we’re doing it”, and we did it and certainly locally there seems to be this culture that it’s the Social Work Department’s problem and I and that annoys me sometimes and I feel well it’s not really, it’s everybody’s issue and the fact that sometimes you did get calls em, “my mum doesn’t have a meal on Friday so you’d better do something about it”, and it’s not really helpful and I know it’s simplistic but I think again we have to create a culture that everyone can have a part in and obviously you have to be very careful about who can do it, who can cope and I think for too long we take charge and I don’t think it does anyone any favours. You get carers who say, “well I’ll contact the day nurse” and I say, “well fine”. I’m not gonna do it for them if they can do it. It’s not that I can do it any better than them. If again they need me to step in at any point then I’m there. I mean we close cases as well you know if cases are stable and there’s a care package up and running that doesn’t need to be overseen then we’ll close that case.

The opening question in extract (66) relates to the increasing complexity of informal care and is met with a preferred response. The informant opens up the narrative with the well-worn topic of concern over the burden on the state due to the increasing requirement for health and social care in a climate of limited resources. She is presenting an argument that individuals have become dependent on the state and are now reluctant to take responsibility for their own kin. The account is presented in terms of a social problem that has been created in part by the state because “we took everything away from the

community". If people encounter difficulties typically they turn to the state to resolve them as, "there seems to be this culture that it's the Social Work Department's problem". Analysis suggests that the speaker is again performing ideological work in working up a particular version of society, which is seen to be failing in its duty to care for its own members. With the use of the word "culture" in this context, society is characterised as having a specific identity where shared moral laxity is deeply rooted in its value system. Note also that the informant deploys the technique of active voicing throughout the extract to give an indication of what people generally say or what they would have said.

The informant goes on to express some disquiet with the situation because it is as she says, "everybody's issue" and that we have to "create a society that everyone can have a part in". The speaker is drawing from a collectivist ideology and is thus speaking the rhetoric of social inclusion. The informant concedes that it is as she says, "quite controversial" and as such she seems to be laying herself open to the possibility of criticism for expressing a radical idea. Potter (1996) discusses the notion of stake confession, an utterance, which is issued when the speaker is aware that a statement may be construed as potentially obnoxious. They are in a sense pre-empting criticism by owning up to something that may be perceived as objectionable. In addition stake confession may also work to present the speaker as someone who is honest and not afraid to express a radical idea.

What is also striking about this extract is the way that the informant is careful to ensure that the listener does not go away with the wrong idea. While she has concerns about

individuals not taking individual responsibility, this is not because she is lazy or unwilling to offer support when it is needed. The informant is acting responsibly in letting informal caregivers to take responsibility. It is not a neglect of duty but a measured response. If they need help, she'll be there. Note also, "we close cases as well", demonstrating with the use of "we" that this is a strategic decision made by the social work team. To close cases when the caregiver is deemed to be coping is custom and practice within the Social Work Department and not down to her own individual ideology.

The interviewer returns to this theme at a later stage in the interview. See extract (67).

Extract (67)

Interviewer: Do you think that people are asked to do too much?

Informant SCM 3: I think that people often take on too much and if we've not got some grand plan to take over then we won't.

The point worth noting in this extract concerns the nature of the informant's response. Note that the question concerns if "people are asked to do too much". Phrased in this way there is an obvious invitation for the informant to implicate formal service providers in contributing to the stress and burden of informal caregiving. Note that the response subtly rejects this and in so doing passes the blame onto the informal caregivers themselves. They are to blame for taking on "too much" and not offering an objection. If no objection is offered then the social care managers will not intervene unnecessarily.

In contrast to the previous extracts in this section, which emphasized the moral imperative to care and the part played by service providers in policing this. The following accounts focus on the difficulties of enforcing informal care and the idea that care offered unwillingly is less productive. A brief overview of previous research suggests that the reasons why individuals and families become involved in informal care are numerous. For example research by Finch (1989) found that support is offered on the basis of duty and obligation. From this Finch argues that for some carers there is significant difficulty in measuring what they feel they should do, against what they want to do. We saw from Land and Rose (1988) that caregivers are often drawn incrementally into caring situations. Research of this nature suggests that a number of individuals may be trapped in unfulfilling relationships in which care is given to a greater or lesser degree, unwillingly. They would rather be engaged elsewhere but feel anxiety and guilt at the prospect of giving up. See the following extract (68):

Extract (68)

Interviewer: What do you think are the qualities that carers should have?

Informant DN2: I think they should be willing to em care. If they're in a situation where they are having to care then they have to want to do it, you cannot just put it upon them. So they need to be enthusiastic about it, kind of keen. Got to be keen.

The informant in extract (68) constructs caregiving as an activity that has to be entered into willingly. If they have to become involved then they have to want to do it.

However, this is contrary to the assertions offered in a later stage of the interview with the same informant in extract (69). This account discusses in narrative form, caregivers who were unwilling and needed encouragement to become involved. There is a clear contradiction here with extract (68), which emphasises willingness as a prerequisite to successful care.

Extract (69)

Interviewer: Do you have instances where informal caregivers are unwilling to get involved?

Informant DN2: Yes well that's quite hard really. There's somebody at the moment. An elderly lady was referred, the family felt that she was unable to take her medication very well and was unable to do her eye drops. We've subsequently been in numerous times and she's more than able to do this and the family have been coming in and filling up her box, been coming in twice a day. They wanted services in but at the same time they are there and are half doing things but not completely and even though the patient herself is perfectly capable of doing her medication and her eye drops the family were [pause] So what we're doing at the moment is visiting on a daily basis and my plan is to cut it down gradually, alternate days to a couple of times a week but at the same time to say "your mum's perfectly well and able, doing really well" and just take it from there because you can't just keep running around doing the same things for her.

Interviewer: You talked a little about the family. Was it a daughter, a son?

Informant DN2: Em it's the daughter-in-law and I think it's the daughter as well. I think the main carer and the person recorded as the next-of-kin is the daughter-in-law.

Interviewer: But they're not willing to get too involved?

Informant DN2: I think previously they have been very heavily involved and I don't know why they want to withdraw. They seem to want to withdraw completely. It's quite confusing. I don't know why they want to withdraw.

A number of analytical issues fall out of this narrative account. Firstly we can read it against the previous set of statements in extract (68) and see obvious contradictions. In the previous text we saw that it was unsatisfactory to force caregivers to fulfill obligations. In extract (69) the narrative gives a clear indication of the informant's attempts to encourage the relatives of the client to provide support. However, it is precisely the problem of the contradiction and variability in accounts that is of interest for discourse analysts. Potter (1998 pg: 244) comments that, "the same individual can be found offering different evaluations on different occasions, or even during different parts of the same conversation". Accordingly Potter goes on to suggest any variability in accounts is often missed or suppressed in traditional attitudinal research. For him such research largely views evaluations as reliable and enduring of insights mental states. Extracts (68) and (69) provide a pertinent example of the difficulties with the idea that individuals carry around with an under the skull, already filled in Likert Scales on a welter of attitudinal objects (Potter 1988). Instead evaluations should be seen as

performative, issued for different reasons depending upon the context and purpose. The informant in extracts (68) and (69) is responding to different questions and different contexts. In extract (68) we see that the interviewer asks, “What do you think are the qualities that carers should have?”, and the informant responds with a preferred response on the matter of willingness or keenness. In extract (69) the question, “Do you have instances where informal caregivers are unwilling to get involved?” is met with a narrative where the informant remembers the problems of a recent case. It could be said that this is representative of the differences between attitudes and behaviour. However, for the discourse analyst it is of interest because it gives an insight into how the informant is meeting the demands of the moment. As we have seen the pairing of question and answers as adjacency pairs in terms of how a question normatively elicits a certain type of response. There is a normative expectation that the response will be relevant to the question and it is likely that it will be either, “no” or a “yes” followed by a narrative, which explains the particular “instance” being recalled.

Secondly, we can look to the management of the account. The description centres on the medication requirements of an elderly lady and her daughter and daughter-in-law’s apparent unwillingness to administer eye-drops. As stated elsewhere the concern of discourse analysis is to uncover whether the account is a tale of truth or fiction but to look at how the descriptions and characterisations are put to work to help build up a factual account. For Bell (1991) all stories have a structure, a direction and a viewpoint. We see that the lady has been referred to the district nurse on the basis that “the family felt that she was unable to take her medication”. At this point the informant is setting the

scene of the account and making it clear that this was the view of “the family” and as such not a view held by service providers. The informant goes on to state that the service provider’s or as she says, “we” did visit “numerous times” and the findings were that “she was more than able” to administer her own medication. Looking at these statements in turn and considering the purpose they serve we can see that the speaker gives an impression that the judgement was based on a consensus of opinion that was built up over many visits. The witnesses agreed. Note also that the final judgement was that the client’s ability showed more than a marginal degree of competence. She was “more than able”. The account is organised to close off the possibility that the family were correct and that the formal service providers had misjudged the situation.

Further into the extract the speaker says that the family had been visiting twice a day to refill her medication dispenser. The point here is that as they were already visiting it would have been feasible and indeed entirely reasonable for the eye drops to be administered by them. They are described as, “half doing things but not completely”, hinting that their input lacks structure and real organisation. Again we see elements of the *bureaucratized carer* account. Throughout the series of statements the informant is building up an account, which both presents the original judgement as sound and based on commonsense. Although the caregivers are clearly being characterised as unwilling, the informant marks her intention to reduce formal service input, contradicting earlier accounts. As stated elsewhere in this thesis accounts frequently contain contrary or “dilemmatic” utterances that give two opposing but in their own way, reasonable positions. It was suggested earlier that as utterances are informed by history and culture it

is not surprising that they reflect a range of ideologies. The world is steeped in a number of ideologies that can be mobilised at any particular time. In the case of extract (68) the informant speaks the rhetoric of anti-oppressive practice in community care, which emphasises taking into account carers needs and choices. Conversely in extract (69) the topic concerns invalidating carer's choices by subordinating their needs to ensure the smooth and orderly running of formal services.

The caregiver is revealed as the daughter or daughter-in-law and we see from this point that the narrative begins to falter slightly as it changes from specific description to something much more vague. It was proposed in chapter four that narrative accounts tend to follow a particular structure and are managed to ensure a successful outcome for the narrator. In particular we saw that narratives typically end with the use of a *coda*, which draws a line under a story. Codas, as Bell (1991 pg. 237) states, "wrap up the action" and signal to the listener that this is the end of the story and that it is now time to move on. For Labov (1967) a coda signals to the listener that further questions concerning the detail of who did what and what happened are no longer relevant. The story has been brought to a close. Returning to the extract we see that the faltering style follows the statement, "so what we're doing at the moment is....", which can be identified as a coda in that it marks a return to the present tense and thus the end of the story. The informant's faltering is suggestive of a discomfort that the structure of the narrative has been breached by the interviewer's return to questions concerning who did what.

It is clear then that as descriptions are the work of the narrator they need to be presented as robust and unproblematic in order to resist undermining. Returning again to extract (70) we notice that it is “the family” who are cited as the caregivers. As the family carries a particular cultural meaning the reader can draw inferences as to the identity of the caregivers and perhaps see them as comprising individual members such as husband, daughters and sons etc. However, we see that following the interviewer’s questioning regarding the exact familial relationship between the recipient of care and the caregiver we see some hesitancy and vagueness from the informant. She is not sure whether it was the daughter or daughter-in-law who was the main carer but concludes that it was in fact the daughter-in-law who was recorded as next-of-kin. We see also the frequent use of “I think” and “I don’t know” through to the end of the extract. Statements such as “I don’t know” for Potter (1996) work as a form of stake inoculation. However, this raises questions as to why the informant would appear to have an interest to protect?

It has been commented upon elsewhere by authors such as Finch (1989) and Qureshi and Walker (1989) that service providers hold assumptions about which family members can be legitimately called upon to provide care. These assumptions are hierarchically ordered and are structured with spousal relationships as the first port of call, followed by co-resident relatives, then the daughter, daughter-in-law, followed by a son and then other relatives. The narrative is built up to persuade us of the caregiver’s reticence. However, on further questioning we see that the caregiver is the daughter-in-law who would in the terms suggested by Qureshi and Walker, occupy a place close to the bottom of the hierarchy. Within the context of the account it may be problematic to expect commitment

from the daughter-in-law therefore this information has been selectively managed to avoid that accusation. As the narrative is managed to present the version as unproblematic or water tight, questions which threaten to undermine the account, threaten the legitimacy of her subject position as main carer and allow the possibility for the informant to be viewed negatively. From the text we see that the informant's vagueness and lack of certainty over the identity of the caregiver demonstrates that she is attentive to the way that this information will be received by the listener, hence the use of "I think" and "I don't know".

6.7 Chapter conclusion

The focus for this chapter concerned the evaluative practices of the informants in relation to "good" informal care. The analysis has suggested that practitioners draw from a range of situations to judge success. The analysis has demonstrated how informal caregivers, who are evaluated positively are presented as having an enduring virtuous personality which forms the hub of their identity. Further, success is judged by a variety of means and is influenced particular by occupational yard-sticks and there was clear evidence that vocational norms and values provide useful resources to inform discourse on informal care. As we have seen the district nurses evaluated informal care using nursing activities as their reference point. Despite nursing being an apparent benchmark for *good* care, in research previously reviewed (Bauld et al 2000) nursing/medical tasks make up a comparatively small proportion of the total range of tasks performed by informal caregivers. Within this context, *good* care can apply to only a minority of caregivers.

The social care managers evaluations had similar qualities to case management, a method of working in social work. Potter and Wetherell (1987) conclude that these two distinctive forms of talk are examples of what they describe as interpretative repertoires. They define them as “basically a lexicon or register of terms and metaphors drawn upon to characterized and evaluate actions and events” (Potter and Wetherell 1987 pg: 138). The data provided a clear indication that these distinctive ways of talking were part of the distinct two vocational areas. As Edley (2001) suggests they are part of a community’s commonsense.

In addition to these repertoires, the informants also drew from normative societal values such as obligation and duty in their evaluations. Insight and the primacy of authentic knowledge, together with the subordinate position of informal caregivers are key issues in the accounts. The analysis has also demonstrated some of the methods used to organise talk, such as the use of narrative to present accounts as factual and to separate the speaker from the ideas expressed.

The focus of the thesis is to investigate the construction of gender in informal care and therefore the issues drawn out of this chapter have direct relevance. For example, Margaret Stacey (1988) discusses the issue of women’s obligations to the family for the protection and maintenance of their health. In the roles of mother, wife and daughter, women Stacey argues, are burdened with heavy responsibilities, which often require the negation of their own needs. Indeed the focus on the avoidance of ill health through the

promotion of healthy lifestyles necessarily places women, as governors of the domestic space at the forefront of health promoting activities within the home. Providing a healthy diet, encouraging the taking of regular exercise, arranging and attending health clinics are activities that are traditionally initiated by women. Thus the burden for the care of sick family members falls to women in the fulfillment of domestic obligations. Thus talk concerning familial obligations is necessarily gendered as a result of the naturalness of female administered care work. For Hilary Graham, women also have the additional responsibility for mediation for formally provided services:

Their responsibilities within the domestic health services unavoidably bring them into contact with professional welfare workers: the doctor and health visitor, the social worker and the district nurse. Their caring role places them at the interface between the family and the state, as the go-betweens linking the informal health care system with the formal apparatus of the welfare state. (Graham 1985 pg. 26)

The *Bureaucratised Carer* and *Responsibility* form of accounting constructs informal care from a range of available and sometimes competing linguistic resources. We see that informal carers are characterised as being the possessors of inferior knowledge but the characterisation also encompasses a repertoire of joint working whereby carers who have a type of knowledge judged to be sufficient may be acknowledged as co-workers. A further account draws from the notion of familial responsibility, which is more suggestive of a work ethic rather than the focus of a relationship based on emotional ties. All of the *Bureaucratised Carer* accounts are contingent upon the recognition of the practitioner as

the controlling agent. Informal caregivers fit into the pre-existing, and one could argue paternalistic hierarchy based on the professional definition of what counts as enough involvement. The *Responsibility* form of account tries to reproduce traditional family and gender relationships. From this perspective men are free to fulfill their role as provider, while women fulfill the role of caregiver and nurturer, both sides taking their familial obligations seriously.

Chapter Seven

The Impartial Assessor Repertoire

7.0 Introduction

In chapter six, discussion centred on the construction of success in informal care and proposed that care is evaluated using both societal and occupational reference points. This is of particular concern to this thesis as such themes provide further means of analysing how informal care is shaped into a gendered occupation by the way that practitioners speak about it. Chapter seven focuses on assessment in informal care, particularly in relation to the assessment of caregiver needs and any relationship that it has to the allocation of resources. Discussion surrounds the various constructions of assessment, but more particularly how it emerges as a process, which acts independent of the assessor. It is argued that needs assessment acts as a vehicle to carry commonsense assumptions on gender and ability to care.

7.1 Assessment in Informal Care

Decisions about resource allocation in community care are made on the basis of assessments. The aim of assessment in the nursing and social work is to determine the needs of the client and the range of services that will be required to meet those needs. The *NHS and Community Care (Scotland) Act 1995* promotes prescribed need whereby need

his assessed by professionals. However, in the first instance a decision must be reached on whether an assessment is required. Generally needs are defined as being normative in that they are measured against of professionally prescribed standards and therefore professionally led and dominated (Braye & Preston-Shoot 1995). Users may participate by expressing a choice but ultimately the decision-making power rests with the professional, thus service users remain at the judgement of practitioners both in defining need and how the need will be met. However, there remains little in the way of a coherent theory of need on which to base the assessments (Baldwin and Woods 1994). Although consumers are in theory encouraged to define their needs and how they should be met, Stainton (1998) comments

The role of the local authority as represented by the social worker is not to define what a person's needs are or how they are to be met, but to negotiate with the individual on what needs are legitimate claims against the state and to support the person in meeting those needs deemed legitimate in ways that are acceptable to them.

(Stainton 1998 pg: 138)

Stainton refers to this as “structural paternalism” in that decisions regarding service provision although made by individual service providers, are inherently influenced by the structure of the organizations.

According to Heron (1998) decision-making has been traditionally informed by the personal feelings of community care practitioners, but argues that this has largely been addressed more recently. Twigg and Atkin (1994) comment that the personal values of health and social service providers form a backdrop to assessment and resource allocation. For them, issues concerning kinship obligation, duty and gender, structure the responses of service providers to informal caregivers. Referring to this as “assumptive worlds”, Twigg and Atkin suggest that many draw on tradition and cultural expectations when prescribing service provision. Indeed Baldwin and Woods (1994) highlight needs assessment as a largely idiosyncratic process and as the power rests in professional expertise, Watters (1996) calls for more research in how professionals apply judgement in this area.

In terms of this thesis, a consistent theme in the data is the notion that informal caregivers have needs, which exist independently from those of the recipient of care. Both sample groups orientated towards *need* as a linguistic resource, which was articulated by every informant. The particular issue of the “carer’s assessment” was significant. With the *Community Care and Health (Scotland) Act 2002* local authorities now have a statutory responsibility to conduct an assessment of an informal caregiver’s own needs, if requested. The caregiver must, however, be providing substantial and regular care to someone who are themselves, eligible for assessment. However, assessment is often conducted on a less formal basis, with the needs of the caregiver being addressed by virtue of their relationship with the patient. Informal caregivers can request to have a separate assessment conducted in a private meeting. Heron suggests that the majority of

carers assessments are part of a holistic framework of considering the needs of the recipient of care and caregiver together.

Further, for Heron there are several over-riding principles to good practice in assessment. Firstly assessment should be “individual and needs-led”. That is, clients should be assessed on the basis of what their needs are judged to be, rather than on the services that are available. This involves the process of “gathering the data” on which to base the assessment and then “analyzing” it to determine how needs could be met (Heron 1998 pg. 63). Secondly, assessments should be conducted with the full participation of the service user. Professionally led assessments are therefore the antithesis of contemporary values within health and social care and indeed the situation should be approached from the perspective of the informal caregiver. For Heron the informal caregiver is the “expert” and they should be in control of the assessment. Thirdly, assessments should be based on principles, which maintain an ethos of collaboration between the spectrum of service providers and service user. A framework of “trigger questions” is suggested as a means of uncovering information pertinent to the exercise. Such questions are orientated towards establishing the extent of the carer’s strengths and needs. Henwood et al (1996) considered policy in community care and suggested that despite an initial slow adoption of the assessment of caregivers needs, there is evidence to suggest that a culture of assessment is permeating throughout the social work departments. However, the assertiveness of informal carers is crucial in determining whether their needs will be assessed.

The final stage in the process concerns resource allocation, which may be written up in the form of a care plan. This document provides information on formal service input and details concerning the time allocation and costs. However, the Social Services Inspectorate (1995) points to the disparity between service agencies in their handling of the care plans, many not sharing them with informal caregivers. According to Heron (1998) and Twigg and Atkin (1994) many carers are left unsure as to whether their needs have in fact been assessed and indeed sometimes there is little documentation in evidence. The investigations to support this thesis demonstrated that the local social work department had produced a document explicitly for the assessment of caregivers needs and that this was in use in some instances (see appendix 2). However, no such document existed for use in the health sector, although informants reported that the formulation of a distinct document had been discussed at various times. This issue had apparently remained unresolved at the time of data collection.

Therefore explicit policies on the assessment of caregiver needs support the system of prescribed need. Thus significant decisions are made within the context of resource constraint, eligibility for assessment, availability of support agencies, informal caregivers own views and evaluation of their strengths and abilities, not least commonsense reasoning on kinship obligation. At the same time, while caregiver's needs are addressed there is a clear lack of consistency between assessment approaches. Social care managers having an assessment tool which is used, either at their own discretion or at the request of informal caregivers. District nurses having no explicit assessment tool. Clearly the assessment of caregivers needs is going on to a greater or lesser degree, with or without

an assessment tool or formal documentation. However, the focus for this chapter is the way that the practitioners discuss assessment and in so doing construct it as a process or event which is independent of the factors described above. At the same time this construction is contradicted with references that confirm assessment essentially as a discretionary operation. See the following example in extract (70).

Extract (70)

Interviewer: Do you think your reaction is different to male carers than it is to women when you're assessing needs?

Informant DN2: No I just go in and assess and I try not to let that influence my judgement. I try not to make judgements but it's very hard sometimes. I try to assess the situation as it is, as their needs are as a whole rather than on this thing or that thing.

Interviewer: So do you rely on to a certain extent carers saying what their needs are?

Informant DN2: You do, you rely on them saying and what you yourself think they're needing and asking appropriate questions to establish what their needs might be. You think about what you did in the past situations that have been similar.

Interviewer: So to a large extent you use your initiative. Is that something that you think works successfully or do you think that you should have a formal system?

Informant DN2: Yes I think we should have a formal assessment tool because not everyone asks the same questions so you're relying on tradition.

Interviewer: So really you're hoping that people are good at communicating their needs. To say I can't cope or I don't know what to do.

Informant DN2: A lot of it as well is that you know, gut feeling. You sense that things aren't quite right either they're not willing to say or they can't say. Sometimes you just sense something. You just take it from there. You shouldn't go in and just be blinkered and do what you have to do and get out. You do a formal assessment and you're assessing all the things. You're assessing the situation.

The essence of the extract (70) above is the recognition that informal caregivers are individual people with diverse abilities, needs and wants, therefore it is down to the professional assessor to acknowledge this and determine on a case-by-case basis, what form of assistance is required. The adoption of this form of accounting is not straight forward in that it paradoxically constructs the assessment of need as an impartial affair but one that is nevertheless contingent upon the judgement of the assessor. Assessment is constructed as something separate from judgement, "I try not to make judgements but it's very hard sometimes. I try to assess the situation as it is, as their needs are as a whole rather than on this thing or that thing". Here we see that the informant is making an assessment but not a judgement, thus constructing assessment as a clinical and value-free activity. In addition she is emphasizing the holistic concept of assessment, encompassing the social as well as the health status of an individual. The informant presents herself as "standing back" and approaching the situation as an independent observer with no preconceived ideas. At the same time situations are judged in relation to tradition and

previous cases. In addition the informant refers to “gut feeling” and a sense that things may not be as they seem.

Towards the end of the extract the interviewer challenges the model of assessment as something that is dependent upon the ability of informal carers to articulate their needs. The informant is alert to the problems in a system, which could rely on prompts from caregivers and that this could be justifiably criticized. An attempt is made to avoid a negative evaluation of both the assessment process and the assessor by underpinning the assessment with a form of intuitive perception. “A lot of it as well is that you know, gut feeling. You sense that things aren’t quite right either they’re not willing to say or they can’t say. Sometimes you just sense something. You just take it from there”. This serves to enhance the status of the assessor and at the same time, answer any criticism. This form of accounting works to establish practitioner judgement as value free and holding across different situations. In extract (70) we see that the informant refers to assessment of carer needs and abilities as being a “formal” assessment. This form of utterance serves to minimise the existence of judgement and so render the professional a passive actor in the assessment process. We see a similar form of accounting in the following extract (71):

Extract (71)

Interviewer: Do you react differently to male carers or female carers?

Informant DN4: I’d like to think not. I don’t think so. I don’t know I’m doing it.

You’d have to ask the people themselves. I’m not aware I’m doing it.

Interviewer: I suppose as you say you can't know when you're actually involved with it but is it the case that perhaps you put in more services and perhaps visit more often if it's a male carer.

Informant DN4: I'm trying to think. On the whole no because you actually judge as you go along. It, I think the person as opposed to the gender is coping or not coping, you go in. You're assessing the situation as you go along.

In extract (71) we see that the interviewer's question is met with a vague response; she would "like to think not". Analysis should therefore concern why this response is invoked. As we have seen in previous sections, questions of stake and interest are of central concern to the discourse analyst. Looking at the detail of the extract (71) we can see that the interviewer's question can be heard as a direct request for the informant to give her position on a controversial subject, gender bias. Clearly the informant is alert to the possible negative ramifications of a response, which could demonstrate a prejudiced position and she therefore turns to vagueness as a means of managing the interaction. The response of "I'd like to think not. I don't think so. I don't know I'm doing it", is a subtle form of stake management. According to Potter (1997) such utterances may be presented as a means of suggesting that the speaker is unsure of their role in the event or situation under discussion. The informant continues with, "You'd have to ask the people themselves. I'm not aware I'm doing it", further resisting the requirement to give a direct response. In addition we see the deployment of a grammatical technique of dividing the self into different agents, which according to Potter and Wetherell (1987) is commonly used in accounting. In this extract the response, "I don't know I'm doing it", sees the self

divided into two agents. An internal self, overseeing and monitoring the self that is interacting with informal caregivers. For Potter and Wetherell (1987) this technique of splitting the self into sub-selves can be useful as a means of disclaiming responsibility for actions or events. Thus in extract (71) the informant is able to render possible discrimination as unconscious or unintentional. A further interesting feature of the extract is the interviewer's acceptance of this account as a valid claim with, "I suppose as you say you can't know when you're actually involved with it..."

The extract ends again with a return to vagueness with the utterance, "I'm trying to think", giving the impression that the informant has not previously considered this as a possibility. Further, in a similar way to the preceding extract (70) the informant constructs assessment as an impartial activity. With, "On the whole no because you actually judge as you go along. It, I think the person as opposed to the gender is coping or not coping, you go in", again the assessor stands back and determines the requirements of the situation and is able to free herself of any "improper" gender assumptions.

In the extract (72) below the informant is working up a construction of what she, as a social care manager understands by assessment. It commences with a question concerning the ideal qualities of informal caregivers.

Extract (72)

Interviewer: When describing good care, what qualities do you expect to see?

Informant SCM3: Compassion is the kind of quality. Sensitivity to need. A kind, gentle approach, consistency, reliability. I suppose just the knowledge people care and they're there. All of these things are valuable qualities. Support, a listening ear emm the knowledge that if you're needed you'll be there. I suppose the qualities they would look for in a carer if they could choose. I suppose some sort of common understanding in circumstances, sense of humour, sometimes these *things are really not funny*.

Interviewer: When you're doing a carers assessment are there things that you look for and then work the services around what you see?

Informant SCM2: I don't know that its as specific as that em I don't know that we look at the qualities but we'd certainly look at the skills they had and what they're able to provide and where the gaps are. What is not possible and what needs to be thought of in a different way by others. We would certainly look at their needs as individuals not in relation to the person who's requiring the care but as an individual carer. What are their needs, what that person could identify and what we could identify. We look at the greater picture. What else is around.

From this extract we see assessment from a number of perspectives, some contradictory. Firstly the qualities are listed with regard to what constitutes good care and are listed as "sensitivity to need. A kind, gentle approach, consistency, reliability". However, these qualities, although cited as the hallmarks of good care, are not judged to be necessary for the maintenance of a situation. Indeed in this version, the qualities of the informal caregiver are not assessed. Instead the informant emphasizes the primacy of caring skills

in informal care. Assessment in this case is defined as being quite narrow, working to identify skills deficit, so that “gaps” can be filled. At the same time we see a construction of assessment as a broad activity. Caregiver’s needs are addressed on an individual basis and separate from the recipient of care, reflecting the views of both the caregiver and the service provider. It is also interesting that the extract ends with reference to “the greater picture”. The practitioner can look at the situation almost from above and consider the situation. Again the assessor is an impartial observer, surveying the arena and also considering “what else is around”. From this perspective, assessment is constructed essentially as service-led, rather than needs led, an approach which runs contrary to the philosophy of contemporary service provision.

The following extract (73) provides a further example of a similar form of accounting.

Extract (73)

Interviewer: So you expect them to have the skills and knowledge to be able to contact you if...?

Informant SCM3: Yeah but on the other hand there’s carers who wouldn’t be able to do that then that’s how you are a care manager you would assess that differently. You would think well, calling this person would probably be worthwhile. You know they’ve identified and you’ve identified that they don’t cope so well sometimes but asking for assistance isn’t that easy for them. You offer that before they get to a stressful situation.

Interviewer: So how do you see that difference then? Is it some intuition that you have where you see whether a carer's going to cope?

Informant SCM3: I think it just depends on the person. I mean some people can actually come out and say, "look I just, I'm not coping" or, and say I well, "give me a call". Or you call so and so, "what about this service". You know they just find that really difficult to do. You just know. A lot of carers you work with can just about be bananas and can have health problems of their own who just aren't used to getting on the phone. I suppose it's a bit of intuition but you're also assessing. You're assessing carers as well so you're so you get an idea you know.

Extract (73) above discusses the theme of carers who can cope with their situation and those who perhaps experience difficulty. Some informal caregivers are described as being reticent in reporting difficulties and this leads the interviewer to question how the practitioner would otherwise detect problems. Note that the issue would not arise because of the assessment. Here we see that the assessment is constructed as a kind of "crystal ball", in that it can predict who will typically encounter problems and have difficulty with reporting them or asking for help. The assessor has, already "identified that they don't cope so well". The interviewer picks up on this and responds with, "Is it some intuition that you have where you see whether a carer's going to cope?" The informant returns with the statement, "I think it just depends on the person", to qualify this proposition. A reliance on intuition is unnecessary because some caregivers are more explicit in stating their needs. For the others, the informant senses that they will not be forthcoming and will even allow the caregiving to affect their own health.

The informant is seen to reluctantly accept the explanation that assessment of need is based on a degree of intuition with “I suppose it’s a bit of intuition”, but paradoxically states, “you just know”. This is suggestive of contradictory positions. However, as Billig (1997) suggests, people make utterances, which fit the rhetorical demands of the moment. These demands centre on the rejection of a kind of “folksy” idea of intuition, which would clearly be seen as flawed within the context of resource allocation and at the same time to acknowledge the depth of experiential and tacit knowledge appropriate for an expert practitioner. However, the explanation swings back to assessment as an impersonal event with “but you’re also assessing. You’re assessing carers as well so you’re so you get an idea you know.”

Such accounts bear similarities with Potter’s (1997) discussion on the *empiricist repertoire*, taken from the work of Gilbert and Mulkay (1984). The two analysts were concerned with the sociology of scientific knowledge and examined through a variety of media, such as lab reports and publications in scientific journals, the production of scientific accounts. Gilbert and Mulkay found that the material under investigation drew on a particular grammatical form traditionally found within scientific papers in which the actions and motivations of the individuals carrying out the scientific studies are minimised. Using phrases such as “the hypothesis proposed” and “these data suggest”, Gilbert and Mulkay demonstrated that scientific accounts impersonalised the reports by constructing the data as something that exists outside the control or manipulation of the scientist. This approach is orientated towards the maintenance of the notion that data has

been treated scientifically and critically tested but without any contamination from an external agent. Such accounts according to Potter construct the data as the agent as it takes on the role of the principal. The informants in the above extracts of text are attempting in a similar way, to separate the practitioner from the business of assessing the needs of informal caregivers and thus attribute the assessment itself with a degree of agency. Again this serves the purpose of bringing an impersonality to the situation to avoid the accusation that the informants are assessing the needs of informal caregivers on the basis of any personal ideology.

The consistent emphasis on the practitioner as an impartial assessor perhaps stems from past criticisms that health and social care were task-centred rather than patient-focussed. In line with the philosophy of individualised care, the nursing process was seen to challenge the de-personalised model of care prevalent in health and social care practice prior to the 1980s (Ford & Walsh 1994). The nursing process asserts that care should follow a framework which centres on planned activities and starts with assessment of the whole patient, moving on to planning, implementation and evaluation. Shetland (1965 pg 115) defines it thus:

.....one of interaction. The nurse enters imaginatively and sensitively into the lives of the people she [sic] serves in order to understand their health needs, determine the perception of their needs, reconcile the difference between the two sets of perceptions and institute appropriate nursing measures in interaction with the recipients of her service.

Within the institutional model of care the patient may be considered in isolation as the sole recipient of the service. However, within the ideology of community care the definition of the recipient is blurred as a result of the complexities in the social sphere. Nevertheless there remains an onus to present care planning and the assessment of need as a scientific process rather than one that is informed by gut feelings or tradition. Sheenan (1991) proposes the following key words for their association with the nursing process: holistic, systematic, scientific, individualised and problem-solving. We see therefore that the informants accounts are constructed to present their assessment practice as scientific and independent of value judgements, as to admit to partiality would challenge their professionalism. Gilbert and Mulkay (1982 pg: 400) suggest that the empiricist repertoire, acts to make the scientist's conclusions appear unproblematic and in need of "no further support". Practitioners from both sample groups talked of assessment in terms just "assessing" or "doing an assessment", an activity with its own ability to show the needs of informal caregivers or to demonstrate how they are coping.

7.2 Chapter Conclusion

Worth (2001) comments that practitioners have difficulty in articulating the nebulous phenomena that is needs assessment and have to rely on both professional values and their own assumptive worlds to inform its meaning. As the concept of need is socially constructed, it is melded with issues such as expectation and identity. Assessment of need directs decision-making in terms of resource allocation and takes place within a context

of resource constraint and commonsense assumptions regarding the obligations of informal caregivers. Assessment necessarily becomes, at least in part, the process by which informal caregivers are placed and cemented into that role. Therefore the ways of talking about assessment becomes valid investigative material. This chapter has focused on the construction of assessment in informal care and analysis has suggested that the practitioners construct assessment in a number of ways. The accounts commonly reflect contemporary values within social and health care provision, vis-à-vis individual, needs-led assessment. At the same time much of the accounting emphasises assessment as a value-free activity. However, it is clear that the construction of assessment as a pre-existing object which is uncontaminated by the values of the assessor has certain difficulties. The assessment is necessarily a both a personal and professional evaluation and it would be difficult to argue otherwise. Ellis (1993) for example found that social work assessments are often guided by instinct and moral judgements. In this chapter it has been argued that it is precisely for this reason that the *Impartial Assessor* repertoire is constructed to give the process of assessment an existence, which is separate from the assessor.

The focus of this thesis concerns not only the construction of gender in informal care but also seeks to investigate the vehicles that carry commonsense assumptions. It is argued here that needs assessment is such a vehicle. Of course it is not intended that the accounts in this chapter can be taken to reflect what happens in practice or to make a connection between the word and the deed. Indeed it is not within the modus operandi of discourse analysis to suggest that what is said is a “true” reflection of people’s thoughts, which can

be mapped onto the “real” situation. Instead the focus concerns how assessment, as an event is formulated to have an existence of its own, which is value free and objective. In other words, that the informants are alert to the need for responses to reflect the current value base of their professions with regard to objectivity and impartiality. In addition how accounts may be received by the interviewer and result in negative attributions. At the same time this has to be carefully balanced with the notion of assessment as a “craft skill”.

Chapter Eight

Conclusions

8.0 Introduction

The start of this thesis provided an insight into the various factors that have combined to allow the emergence of community care as the preferred model for care in the United Kingdom. Dominant accounts include economic imperatives such as the spiraling costs of contemporary health and welfare services. This is considered together with an increasing demand for service provision and both have created an impetus for a change towards individual responsibility. In addition the shifting ideology has also been fueled by humanitarian concerns and the need to address the inadequacy of the institution as a setting for high quality care. With the change in paradigm away from institutional care and towards community care, informal caregivers have emerged in the translation of community care into family care. Informal caregivers are increasingly recognized as a form of service provision, but they remain largely unpaid and until comparatively recently, unrecognised.

A significant critique in the debate about community care has been developed by feminist authors, who have pointed to the reliance upon the unpaid labour of women, caring for family members. Falling out of this are a variety of issues, which have come under feminist scrutiny, not least assumptions regarding the nature of kinship obligation, which

are said to underpin the community care model. Health and welfare services, within the feminist critique are seen to operate against a backdrop of normative ideas regarding the nature of caregiving in terms of its meaning and operation (see for example Skidmore 1994; Graham 1993; Hanmer and Stathman 1999). For this reason, the world of informal care has provided fruitful ground for investigation (Green 1988; Twigg 1992; Twigg & Atkin 1993; Bauld 2000). Understanding has been enhanced in a number of areas, particularly in establishing the demographic profile of informal carers (Finch & Groves 1980; Nissel & Bonnerjea 1982; Finch 1984; 1990; Ungerson 1987; Baldwin & Twigg 1991). As caregiving brings with it considerable disruption to daily life, further interest has lain in the impact of caring on informal caregivers, in relation to both the positive and negative effects of and on the relationships between kin. Allied to this is the search for ways to meet the needs of informal caregivers and so reduce caregiver burden and stress (Glendinning 1992; Qureshi 1990; Arber & Ginn 1992).

A significant theme has been the exploration of the factors motivating informal caregivers, in terms of their perceptions of duty and obligation (Nolan et al 1996; Cartwright et al 1994; Kane and Penrod 1995). Further study has also been conducted into the interface between informal and formal service provision (Twigg et al 1990; Atkinson 1992; Atkinson & McHaffie 1992).). Of course there is little doubt that women predominate in the world of informal care. While some studies have investigated the gender dimension of caregiving, none, have as yet, empirically investigated how community care practitioners construct informal care as a gendered activity. This thesis therefore offers an original contribution to knowledge in this field.

As we have seen in earlier chapters, men and women are commonly portrayed as inhabiting opposite and indeed fixed ends of the spectrum. Both men and women are viewed as having particular psychopathologies that are gendered. Men for example are characterized as less emotional and more dominant (Conway 2000). Women are regarded as having natural feelings of empathy towards other's distress (Davis 1983). However, according to Hare-Mustin and Maracek (1994) such reductionism merely caricatures human experience, and does not reflect the diversity or indeed the fragmentation of identities. So the interest lies in the idea that gender, rather than being the result of natural biological phenomena, is instead a product of discourse.

The concern of the discourse analyst is to look at language in use and this study sought to investigate the way that community care practitioners construct the identity of the informal caregiver by imposing a range of attributes, which determine its nature. The method of discursive psychology draws from a number of traditions including conversational analysis as well as Bakhtinian and Foucauldian ideas. Therefore the data analysed in this thesis has encompassed both broad analytical themes as well as some of the fine-grained analysis within the conversation analytic tradition. It is important at this point to remember that the over-riding feature of this approach is that descriptions and accounts construct the world, but also that descriptions and accounts are themselves constructed from the linguistic resources available. Therefore the analysis concerned how gender is constructed within the context of informal care and at the same time, how the accounts of informal care are constructed from existing resources.

Twelve interviews were carried out for this study, comprising six social care managers and six district nurses. The central idea was that as these two groups of practitioners are key players in the assessment of need, they control informal caregivers' access to services. It was expected that interviewing these two groups of practitioners would yield empirical evidence to support the idea that gender is constructed in informal care. The research questions are presented below.

8.1 Research questions and substantive findings

1. How do service providers construct versions of the informal carer?

We saw throughout the analysis in Chapters four and five the notion of essential and enduring gender identities. The community nursing informants frequently referred to gender behaviours as natural and therefore outside manipulation. A common linguistic resource was evident, which classified women as having an instinct for caregiving and this instinct provides a natural quality to the activities. Because caregiving for women is natural, it is more authentic and thus men who provide care are akin to actors playing a part that does not reflect their real identity. In addition women's caregiving is a generic skill that is honed through the apprenticeship of childbirth and childcare. Clearly the implications for women are obvious in that if they are pathologised in this way then their involvement continues to be idealized.

Chapter five concerned the construction of male identity. The data gave an insight into gender as a socially proscribed state, which imposes restrictions on behaviour. We saw the way that practitioners refer to a conventional stock of knowledge on what it means to be male. With this type of knowledge male caregivers are not so much portrayed as being unsuitable, although that was a feature of the deviancy form of accounting. More that they are busy with other things and these other and importantly, unspecified activities countenance non-involvement. Men it seems have things that they need to be getting on with.

In the introduction to Chapter Four it was pointed out that men are frequently seen as having a greater connection with the outer sphere and seek control over the physical world. It is clear that talk of the “other things” that are a drain on men’s time, are essentially burdens not from the domestic sphere but from the outer sphere. However, men can be involved in caregiving but because of the demands made on them from the outside world they need to be released if necessary in order to maintain this connection and to meet their commitments. Despite minimal involvement in caregiving, we see from the data that men can still be very caring and that this is evident in activities such as shopping and patient transportation. However, this is further evidence of men’s caregiving work at the periphery, almost on the outside.

The data also supports the idea that ideology permeates discourse. We have seen in earlier chapters that community care as a concept is underpinned by an ideology of individualism and these values are clearly evident in the data. For example many of the

evaluations offered by the informants concerned the issue of personal responsibility. In line with Billig's argument, ideology becomes the commonsense of a society (Billig 1988). Thus, to take responsibility for the care of one's family members is part of the taken for granted knowledge of practitioners, who are immersed through education and practice in such values. Clearly the expression of these values performs ideological work by fulfilling the ambitions of the state in creating an independent society. Of course the gender issues that fall out of such ideology are clear in that women have been naturalized as the providers of family care and are chiefly the bearers of responsibility in this area.

2. Which interpretative repertoires are used by service providers, in the evaluation of informal carers?

It is clear from the data analysis that the informants used a number of linguistic resources or discourses in their evaluations. However there were a number of broadly similar and distinctive ways of talking about informal care. These interpretative repertoires evidence a particular understanding of the world. For example it was common for informal care to be related to aspects around the domestic sphere for example, childbirth, childcare and housework, particularly in relation to women. Male administered care was invariably linked to the spousal relationship or else to involvement with activities outside the home.

The data was also clear in the proposition that because of the very personal nature of the tasks often required, that the male administration of care is at best inappropriate if not culturally prohibited. The examples of personal or intimate care offered, centred on the

spousal relationship, with intimate care in other relationships constructed as deviant. Within this context, male caregivers are engaging in behaviours, which lie outside the bounds of what is normative and are thus open to the accusation that they are potentially abusive. The implied question concerns, what reason could a man have in administering personal care. The constructive nature of this of course is that men may restrict activities to the fringe of caregiving behaviours, such as shopping and driving in order to avoid accusations of deviancy. These metaphors were frequently drawn upon to characterise events or objects and thus it can be said that they are part and parcel of the informants' commonsense.

3. How are the interpretative repertoires used to position informal carers?

Research questions two and three are interrelated and should probably have been combined at the outset. Research question two related to how the informants' evaluated informal caregivers. Question three centres on positioning, however, these two aspects are heavily linked. The constitutive force of evaluations serves to position caregivers as belonging to particular categories, for example good or bad, or main caregiver etc and the data has demonstrated this effectively throughout Chapter six. It is clear from the data that there is a shared interpretation of what it means to be an informal caregiver and this talk is replete with evaluations. Each extract incorporates particular interpretations which caregivers are "invited" to conform to. Indeed in some cases there is a requirement to conform if they are to continue their caregiving activities. We saw for example the account featuring the deviant caregivers who were "classed" as carers and would have

their Carers Allowance removed if they did not participate in the discursive practice of caregiving or belong to that world in certain ways. To be members of that community there would be a requirement to demonstrate the normative/appropriate behaviours associated with the world in which they inhabit. Evaluations therefore, are based on the current “truth” about caregiving and this is used as the benchmark. Informal caregivers are positioned by the discourses used and therefore gender inequalities become well established.

4. What differences and commonalities can be identified in the interpretative repertoires of community nurses and social care managers?

The data evidenced responses that were very specific to the vocational areas of the practitioners. Thus social care managers discussed good care within the professional remit of a social care manager, with reference to care management. In the same way, the district nurses talked about caregivers within a framework of nursing, with particular reference to quasi-medical activities. These findings may not appear to be groundbreaking but nevertheless they have clear implications for informal caregivers. Previous research has suggested that service providers have expectations of informal caregivers based on commonsense ideas of family, kinship, obligation and role. The assessment of need is coloured by judgements on such bases and it is possible therefore that the support offered is commensurate with these expectations. Thus, if informal carers are judged according to a set of vocationally relevant characteristics, what are the implications for those without a good vocational fit? Moreover, both of these evaluative

repertoires ignore other possible constructions of good care. For example, both vocational stories fail to acknowledge the emotional story of caregiving. To put it another way, what of the caregiver who is inadequate in terms of nursing/medical proficiency and the care management skills, but cares deeply at an emotional level? Clearly the data analysed in this thesis suggests that this is acceptable for male caregivers and begs the question of whether it would be acceptable for females?

5. How to service providers describe needs assessment and how does their accounting of this process incorporate gender assumptions

The assessment of need directs decision-making in terms of resource allocation and takes place within a context of resource constraint and commonsense assumptions regarding the obligations of informal caregivers. Assessment necessarily becomes, at least in part, the process by which informal caregivers are placed and cemented into that role. Therefore the ways of talking about assessment becomes valid investigative material. Chapter seven has focused on the construction of assessment in informal care and analysis has suggested that the practitioners construct assessment in a number of ways. The accounts commonly reflect contemporary values within social and health care provision, vis-à-vis individual, needs-led assessment. At the same time much of the accounting emphasised assessment as a value-free activity. However it is clear that the construction of assessment as a pre-existing object which is uncontaminated by the values of the assessor has certain difficulties. The assessment is necessarily a both a personal and professional evaluation and it would be difficult to argue that otherwise. Ellis (1993)

for example found that social work assessments are often guided by instinct and moral judgements. Chapter seven argued that it is precisely for this reason that the *Impartial Assessor* repertoire is constructed to give the process of assessment an existence, which is separate from the assessor.

The focus of this thesis concerns not only the construction of gender in informal care but also seeks to investigate the vehicles that carry commonsense assumptions. Chapter seven argued that needs assessment is such a vehicle. Of course it is not intended that the accounts can be taken to reflect what happens in practice or to make a connection between the word and the deed. Indeed it is not within the *modus operandi* of discourse analysis to suggest that what is said is a “true” reflection of people’s thoughts, which can be mapped onto the “real” situation. Instead the focus concerns how assessment, as an event is formulated to have an existence of its own, which is value free and objective. In other words, that the informants are alert to the need for responses to reflect the current value base of their professions with regard to objectivity and impartiality. In addition how accounts may be received by the interviewer and result in negative attributions. At the same time this has to be carefully balanced with the notion of assessment as a “craft skill”.

6. How do informants deploy linguistic techniques to protect social and professional identity?

The second, more fine-grained approach to the analysis of the data hinged on the interaction between interviewer and interviewee. As we have seen, gender, like topics such as race, has the potential to create difficulties in a discussion and significant interest for this study related to the way in which this “difficult” subject was managed. How would the parties involved organize their discourse in ways that would avert or minimize potentially troublesome questions or responses to questions? As Potter and Wetherell (1987) suggest, discourse involves work in that speakers are constantly engaged in an effort to have their version of accounts accepted as factual and unbiased. Moreover it considers the way that the participants of interaction adjust footing and deploy techniques of stake inoculation and confession. Further consideration is also made to the part played by narrative in both constructing identities and building up facticity.

To these ends this study successfully demonstrated the range of techniques skillfully deployed by the informants. This type of analysis does not merely have descriptive relevance but displays how informants construct gendered identities and at the same time, stand back from these constructions. The data demonstrated the techniques used in conversation to disown the constructions or provide mitigation the creation of subjectivities. In using “nature” or “instinct” justifies gender differences and gender inequalities by normalizing them and making them appear invariant (Gerstel 2000). Stainton-Rogers (2003) citing Vickers (1982) talks of the way that language is deployed to obscure agency or accountability by stripping away the context with the result that *conventional* versions of the world are allowed to be passed off factual.

The idea of a gendered division of labour in caregiving is of course well documented but this thesis offers an expanded insight into the issues. More importantly it implicates service providers in the social construction of this division. Of course the point is that an espoused value within the contemporary delivery of care centres on an androgenous approach whereby practice is broadly anti-discriminatory or equalities based. Certainly the responses indicated an awareness of the gendered division of labour in informal care and were keen to discuss it and at the same time offer an egalitarian account. However this position was frequently contradicted in the same interaction. The difficulty of course lies in how to manage conflicting ideologies in responses and in particular how to manage the problem of offering perspectives that fly in the face of a gender neutral approach. Indeed the data demonstrates how the informants were mindful of such problems and this forms the second strand to the analysis, aimed at uncovering the linguistic practices employed in interactions. As Stainton-Rogers (2003 pg: 223) comments, people are not naive but instead use language purposively and often “deviously”.

This is why approaches, which would seek to uncover attitudes would be inadequate to capture the complexity of informants accounting practices. It is important to reiterate that the interviewees are not giving accounts of their internal states but instead are constructing versions of informal carers and their characteristics and actions. The net effect is that the reasons why women have a disproportionate involvement in caregiving are constructed as being “out there” in the world and as such nothing to do with the informants. The speakers themselves cannot be held accountable; it is a problem of

individual caregivers and society as a whole. Women are either born with this facility, or it is a quality that is nurtured, or it occurs through normative expectations by and from people external to the informants. Moreover the informants' accounts are structured to portray themselves as actively struggling to redress or come to terms with this problem.

8.2 Evaluation of the research findings

The conventional criteria for the evaluation of research centre on well-established concepts concerning reliability, validity, generalisability, originality, fruitfulness and limitations. This section seeks to address these points in turn in relation to this project. For Hammersley (1990 pg: 57) validity refers to "the extent to which an account accurately represents the social phenomena to which it refers", while reliability is defined as 'the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions'.

Firstly the analytic claims made in this thesis are coherent in that they present a tight case for the findings. The broad aim was to investigate how informal care is constructed as a gendered activity and the analysis has presented convincing examples supporting this. The data extracts demonstrate how the informants construct their own identity and the identity of informal caregivers in talk. The analysis in this thesis has shown how a focus on the interview talk provides a powerful insight into both the linguistic practices of the practitioners and their conventional stock of knowledge. At first a broad perspective was taken to uncover the main analytical themes. These themes gave an insight into the range

of possible discourses available to the informants that could be drawn upon in their evaluative talk. Informal caregivers within this context are created by language that is used to describe them. This thesis successfully demonstrates that informal care, as a concept does not come from within the individual, instead it is shaped by the practices and meanings surrounding it.

A second method of validating discourse analytic research concerns the issue of how the informants themselves recognise inconsistencies, variability and potential difficulties in their own accounts. The data also successfully demonstrated the reflexive nature of question and answer sequencing. One of the central methodological points of this study was that interviewee responses would be treated as responses that were specific to the interview situation and therefore organised to accomplish the rhetorical demands of the moment. This approach differs from traditional research methods, which frequently seek to uncover mentally stored attitudes to gender. It has been previously mentioned that variation in accounts is of interest to the researcher, but it also serves to demonstrate the validity of the claims being made when the informants themselves have recognised it and engage in attempts at repair. This was effectively demonstrated throughout the analysis.

As suggested in Chapter three it is generally not the case that claims are made for mass generalisation of research findings within the discourse tradition. However, according to Perakyla (1997 cited in Silverman 2000) the basic structures of the social order are to be found anywhere and thus if we look to any case we will find the same order. It has been argued throughout that because we largely inhabit the same social world we are informed

by the same discourses. Thus we have a conventional stock of knowledge that is gleaned from a huge variety of sources. Therefore if an individual or group is discussing gender they are likely to draw from what is established or known about that concept. The point is that the findings of investigations into gender, based on a discursive methodology should be the same because discourse is based on shared linguistic structures and resources. Thus it is likely that the findings from this research would be generalisable, not just in terms of other theoretically grounded samples of community nurses and social care managers, but to a wider population, because of the pre-existing linguistic resources that are available to a society as a whole.

A further criterion of evaluation concerns fruitfulness in that the analysis should generate fresh ideas and make unexpected discoveries. The analysis and subsequent reporting of findings have been successful in this regard. For example, Twigg and Atkin (1992) commented that a valid area of investigation lay in exploring the assumptive worlds that practitioners inhabit. Clearly a discourse analyst would find research exploring assumptions problematic, as it would imply an “under the skull” approach to investigation. However this thesis has made a clear and original contribution to understanding of the discursive practices within practitioner communities and of course it has successfully argued that these practices form the object and bring it into being.

Further, research has demonstrated that male caregivers are more likely to be offered formal service provision to augment the care that they provide (Lund and Caserta 2001). As we have seen, discursive practices function to construct objects as having distinct

characteristics. The feminist consciousness is underpinned by the idea that male dominance has become naturalised within key social institutions where masculine is privileged within a patriarchal hierarchy (Coward 1984). Individual practitioners working as street level bureaucrats represent the social institutions by reflecting and cementing particular cultural constructions. This thesis offers an original contribution to understanding and explaining the reasons behind the findings of Lund and Caserta (2001).

Research question four focused on comparing the interpretative repertoires of the two sample groups when talking about informal care. Although differences in forms of accounting were anticipated from the outset, it was not expected that they would mirror the vocational role of the practitioner groups. This was an unexpected discovery and as such represents further evidence of the fruitfulness and originality of the research.

To summarise, this thesis has significant relevance to current debates within informal care. After a number of political battles, informal carers have achieved some degree of recognition and while it may appear that the new visibility has addressed some of the difficulties, this thesis has successfully demonstrated that there is further need to contest, subvert and challenge certain “truths” about community care. As truth is never fixed, there is hope that new critiques will emerge offering new discourses.

In the final evaluation of this thesis involves consideration of its limitations. It is at this point that it becomes important to consider the identity and values of the researcher. It has previously been commented in this study that in traditional positivistic methods there is an attempt to avoid or remove any aspect of partiality and subjective judgements of the researcher. However within discourse analysis the values of the researcher are openly acknowledged. As Taylor (2001) comments, the researcher is likely to conduct a study that is of a particular interest to them but this in itself does not constitute bias, merely a position to be acknowledged. The researcher conducting this study has a professional qualification in nursing and has had extensive experience as a district nurse. This background provides important insights and linkage to the world of community care. Having this particular world-view is a benefit to data collection with respect to knowing the questions to ask. Moreover a professional insight can significantly aid data analysis as the terms used and the commonsense knowledge within community care are specific to this occupational area. In addition to the vocational insight, a concern to uncover the construction of identities and subjectivities is a clear indication of a feminist consciousness.

The extent to which these positions affect the interpretation and indeed collection of data can only be guessed at, but can non the less be acknowledged. In earlier sections of this study it was suggested that ways of talking construct the social world but also that the ways of talking are themselves constructions. Taken to its logical conclusion, this thesis itself is a construction in that the knowledge produced is not neutral, and is not oriented towards establishing universal truths. It is merely an interpretation and its partiality

comes from a feminist concern to investigate the nature of a phenomenon within the sphere of community care.

8.3 Recommendations for future work

There is considerable debate regarding the extent to which an interview can ever be considered naturally occurring. Data was collected for this study from research interviews with the knowledge and consent of those taking part. In an ideal situation it would have been collected, with the full knowledge and consent of the participants but in a “real” situation such as between informal caregivers and practitioners in the clinical situation. Future work would be to investigate the interactions between practitioners and informal caregivers during needs assessment to examine gender assumptions “on the ground”. In addition the sample could be extended to include other actors in community care such as Home Carers, General Practitioners or professional allied to medicine for the purpose of comparing forms of accounting.

8.4 Implications

One of the quandaries identified by Taylor (2001) concerns the extent to which, the findings of qualitative research can be applied when the knowledge generated is acknowledged as situated and partial. Despite the idea that knowledge cannot exist as fact, Hammersley (1992) argues that we can be “reasonably confident” in findings and that they can have implications for practice and policy. Although the issue of the

gendered nature of caregiving is well documented, this study provides us with a version of informal care, which previously has not been heard and indeed it supports the position that community care practitioners have a hand in constructing this position. Indeed because the study has revealed previously uncovered knowledge on the accounts and interpretative repertoires used by formal service providers to justify a construction of caregiving as gendered, this knowledge can be used by informal caregivers to resist these constructions. In sum this study has demonstrated how women's care is legitimated by the pathologisation of caregiving. The effects of this are that women are "locked" into providing care. However the findings of this study have shown how such "locking" occurs and this knowledge can be used to challenge the status quo. Of course the analysis also provides evidence of how male caregivers are "locked out" of informal care.

In addition this thesis has offered implications beyond the current level of academic debate in demonstrating the complexity of interview interactions in relation to gender. It has previously been noted that traditional approaches to investigating gender do not take into account the variability in talk. Therefore a method of discourse analysis was identified as the most suitable technique for uncovering any complexity. Inconsistency in responses has been identified as a problem and thus discursive psychology offers a very suitable alternative as a means of exploring this variation. As gender is a contentious issue it is very likely that variation and contradiction will occur. Community care practitioners are exposed to multiple discourses from both their social and professional worlds. Some of these discourses can be competing and this study has successfully

demonstrated how these discourses are drawn on to produce a convincing and “sense-able” response to interviewers questions on a contentious and potentially damaging topic.

Of course within this tradition it is unacceptable to attribute one or another of these discourses as the informant’s “real” opinion and one that would influence their practical decision-making. Nevertheless the study has demonstrated an important issue, which is that when comparing the interpretative repertoires of the two sample groups, it is evident that the community nurses lack the anti-discrimination or anti-oppression vocabulary of the social care managers. According to Phillipson (1992) a radical, anti-oppressive agenda is a key principle of social work practice. This perspective forms an important component of social work education. However the same is not true for nurse education, with exposure to the concept of equal opportunity and anti-oppressive practice being limited to discussion at a general level and not explicitly addressing the issue of gender. This study has demonstrated that the social care managers were much more reticent in their responses concerning gender, perhaps because the equal opportunities discourse is readily available. The district nurses lack of exposure clearly limits the way that they can talk about informal caregiving.

Like all occupational areas, nursing has a particular cultural history. Social work has a much more recent history with the introduction of Welfare Officers that emerged out of the welfare state. Its knowledge base is in the social sciences and therefore has different cultural baggage. See for example the International Association of Schools of Social Work (2002) definition:

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at points where people interact with their environment. Principles of human rights and social justice are fundamental to social work.

The knowledge base in nursing however has historically been found in the biological sciences, which does not have a well-developed awareness of issues concerning discrimination and the differing forms of oppression. See for example the Royal College of Nursing (2003) definition:

The purpose of nursing is to promote health, healing, growth and development, and to prevent disease, illness, injury and disability. When people become ill or disabled, the purpose of nursing is, in addition, to maximize distress and suffering, and to enable people to understand and cope with their disease or disability, its treatment and its consequences. When death is inevitable, the purpose of nursing is to maintain the best possible quality of life until its end.

The cultural and historical baggage of nursing has become its commonsense and thus influenced the ways in which nurses can talk about nursing or informal care. The obvious recommendations in this regard would be for nurse education and continuing professional

development to have a greater emphasis on contemporary theoretical debates that explain discrimination.

As Edley (2001 pg: 195) comments

Masculinity may well exist as a set of discursive practices which inform the way men speak, feel and think, but it is important to understand that many of these practices do become utterly familiar, so thoroughly routinized and automatic, that most men (and women) mistake history for nature.

Women's caregiving is so routine that it is interpreted as nature, as is men's lack of involvement in caregiving. This "knowledge" about caregiving is treated in the accounts as neutral; merely reflecting what is "known" about caregivers. However in Foucault's terms this is a "regime of truth". This "truth" firstly allows informal care to be created as a mode of care (although it had always existed but never as a particular discourse) and secondly, it defines its very nature. Of course it is difficult to locate the source of power within the Foucauldian frame of reference, as it is not held by any one group. Instead it permeates all social relations and structures and is present in all social interactions. However where there is power there can also be resistance, but resistance is dependent upon uncovering the mechanisms by which such "truths" are communicated.

There is a movement towards inter-professional education, which would bring nurses, social workers and allied health professions together and thus offer significant cross-

curricula input. This is already well established in England and Wales and looks set to be introduced in Scotland.

Appendix 1

Topic guide

- What is your highest qualification?
- How would you describe your typical client group?
- Talk me through a couple on your case load at the moment and to try to give me some insight into the issues and range of services available?
- Do you have much contact with informal carers?
- Can you give me examples of informal care?
- Is there such a thing as good care and bad informal care?
- Examples of above
- Do you have any explanation for the gendered dimension in informal care?

Appendix 2

Transcription DN 2

Interviewer: What is your highest qualification?

Informant: Two BA degrees, a District Nursing Diploma and an RGN

Interviewer: What would you say is your average client?

Informant: Well the majority of the caseload of this area is elderly, some over the age of 70. I would say that most of them are single. We do a lot of venepuncture. Many have palliative care needs but are not in the terminal stages of their illness.

Interviewer: Do you have very much to do with informal carers in those situations?

Informant: I do come across patients who have brothers and sisters, sons and daughters.

Interviewer: Can I get you to talk about a couple of people that perhaps you have on the caseload at the moment that stand out in your mind that your involved with. Just to talk about that particular person, if they have any informal care, how things went generally, what kinds of services?

Informant: One that we have at the moment. It's quite difficult referring to other services. He's a chap in his fifties. We had him on previously. The GP referred him on to us. He's an alcoholic. His wife has been in contact with her (the GP). Quite distressed saying that she couldn't cope any longer at home. We went to do a home visit last week but it's been very hard because she works full time and she's never actually there. So all the contact I've had with her has been on the phone at work and because of the fact he's an alcoholic and he's not willing to give up drink there's really very little support in the community

for his wife and him. So spent quite a long time last week ringing around various organizations. So I range around various support groups for alcoholics and they basically said that there isn't any help available unless this chap gives up drink which he's not willing to do. So I've referred him to the drugs and alcohol social services to see if they can help in any way because this guy's at home all day and she's at work and she doesn't want to be off her work and give up work, em but I feel she's in need of support. But its very difficult that because she's not physically in the house to attain anything.

Interviewer: That must put her under a lot of pressure, having to be at work and at the same time meet his needs.

Informant: Yes, uh, yes he's very debilitated and because physically his progress is very poor.

Interviewer: That's quite discriminatory that he doesn't have access to services and that he can only get services if he gives up alcohol.

Informant: Yes there's quite a gap really in the services.

Interviewer: How is she coping?

Informant: Well when she came in to see Dr. * she felt that she really wasn't coping at all but when I phoned her the next day, I didn't have her number to phone her the same day. She felt a bit better when I phoned her the next day. She'd had a good night's sleep. She feels, I think, her work. She gets quite a bit of support from going to work. I don't know, I'm just assuming. That's the assumption. I think she was realistic about things. She knows there's a problem and that he's not going to stop drinking and I think she buys stuff for him. She copes in the best way she can. I think it's on a day to day basis.

Interviewer: How much support does she get from you?

Informant: Well last week was the first visit that I've done and basically its weekly support visits at the moment. There's not a lot of particular nursing requirements. He does have potential ones but yes there's no one else going in. I think he needs a bit of assistance. She gets him washed and dressed and he is very disheveled. There isn't really a need for a home help. There isn't really a need for social care officers to go in and wash and dress. He needs help to get back to bed, but she's back from her work. So although she's fulfilling that what I'm trying to for is a befriending service for him.

Interviewer: So you think that is where he's at, at the moment in terms of his needs?

Informant: Yes.

Interviewer: What about another case you've been involved with?

Informant: There was a lady. It must have been about a month ago. She was referred from hospital. She had an MI. She's discharged now. She's now in the care of her husband who is very caring, tries to do everything. She had her bed downstairs. He was helping her up in the morning, dealing with her medication. I think they also have two or three daughters who live locally going in regularly to see how. She's a diabetic as well so we go in and check her blood sugar and suss out how he's managing. We sorted out a NOMAD. She was admitted to hospital eventually and ended up dying.

Interviewer: And what services were going in?

Informant: Em, us. I don't think there was very much other going in there. I can't quite remember but if there was it was very limited and only about once a week because he has two daughters who where very close by and did everything.

Interviewer: And was he attending to her physical needs as well? Her personal needs.

Informant: I think he was assisting with it yeah. I think helping to get her up. She could move without difficulty. She had a few physical needs but not a massive amount.

Interviewer: Were the daughters keen?

Informant: They were. They were around once or twice a day. They both worked full time as well so they were around during the morning period.

Interviewer: And did you feel this was a successful outcome, although she went into hospital and died?

Informant: Yeah.

Interviewer: Do you think of informal carers as co-workers or co-clients?

Informant: Em, a bit of both I think really. I think they are definitely co-workers. Often you have to assess them to see whether they are willing and able and if they are then you have to assess whether they are capable of contributing to care so you look at explaining what you're doing. Why you're doing it. So you're educating them. Showing the how to take over. It's like with the medication. I think they're also clients as well in that they have needs so you might hand over the eye drops and then leave it and if they're involved with anything complicated you have to consider that they will find it stressful.

Interviewer: Do you have any instances where carers are unwilling to get involved?

Informant: Yes well that's quite hard really. There's somebody at the moment. An elderly lady. She was referred. The family felt that she was unable to take her medication very well and was unable to do her own eye drops. We've subsequently been in numerous times and she's more than able to do this and the family have been coming in and filling up her box. Been coming twice a day. They wanted services in but at the same time they were there, and half doing things but not completely even though the patient herself is

perfectly capable of doing her own medication and the eye drops. The family were. So what they're doing at the moment is visiting on a daily basis and my plan is to cut it down gradually, alternative days to a couple of times a week but at the same time to say, "your mum's perfectly well and able, doing really well" and just take it from there because you can't just keep running around doing the same things for her.

Interviewer: You talked a little about the family. Was it a daughter, a son?

Informant: Eh, it's the daughter-in-law and I think it's the daughter as well. I think the person recorded as the next of kin is the daughter-in-law.

Interviewer: But they're not willing to get involved?

Informant: I think previously they have been very heavily involved and I don't know why they want to withdraw. They seem to want to withdraw completely. It's quite confusing. I don't know why they want to withdraw.

Interviewer: Do you think there's such a thing as good carers and bad carers?

Informant: I wouldn't really say there were bad carers.

Interviewer: How would you describe them?

Informant: I think there are some carers that are less willing to take advice and there's some carers who don't believe what you have to say but that's not always to the detriment of the patient. I wouldn't necessarily say there were bad carers.

Interviewer: Is there anyone that springs to mind?

Informant: No not really. You come across those but no one I can think of.

Interviewer: What about at the other end of the spectrum in terms of good carers? Do you have any examples?

Informant: One case that we had last year that springs to mind. A husband and wife and the husband had cancer and he came home to die and she was absolutely the model carer. She just did everything you told her. Just listened to you. She cleaned his mouth out two hourly on the dot. She know about checking his heels for pressure sores, put cream on his heels. The bed was just perfectly made. She gave him sips of water so frequently and drink. She was just. The medication. She had everything down. I mean you never meet anything like that. She was just the best carer I've ever met. She was great, she was very open to communicating. She was very keen. Very anxious to do everything right.

Interviewer: And did that have a successful outcome?

Informant: Yeah, yeah. He died at home.

Interviewer: And did you have a lot of input?

Informant: Yes he had a syringe driver.

Interviewer: What do you think are the qualities that carers should ideally have?

Informant: I think that em, be willing to em care. If they're in a situation where they are having to care then they have to want to do it. You cannot just put it upon them. So they need to be enthusiastic about it. Kind of keen. Got to be keen.

Interviewer: Have you ever had to persuade anyone to get involved?

Informant: Em, I can't think of a particular situation. I've had people that needed encouragement. That don't know what they should be doing. They're a bit scared or something and that makes them reluctant. Yeah, you have to encourage them slightly. They have to be informed about what's gone wrong. They're a bit more, a bit more keen.

Interviewer: Have you had situations where carers have said, "look I've had enough, I don't want to do this any more"?

Informant: Yeah, I have actually yeah. I remember one case where a lady cared for her mother for about twenty years. So she rang up and just said, "I've had enough". I can't remember what had precipitated this. Whether her mother had, had an illness which kind of made her a bit more immobile. She was having regular respite anyway. But she rang up and she had a Care Manager who sorted out emergency respite for a couple of weeks and that just gave her enough time to recharge her batteries. Oh, I remember now. It was the daughter herself who had the chest infection. She was unwell and that's why she felt she couldn't cope. She had no other help at all and that was her choice and that's why she felt she couldn't cope.

Interviewer: So she had respite and then went back and things carried on as normal?

Informant: Yeah.

Interviewer: How do you think carers might be better supported?

Informant: Well I think that they perhaps need to be more aware of what is available. There's a lack of awareness perhaps of what is available, what's already established and what supports there are. Where there's a patient with dementia and I just feel that there are big gaps where some cases are isolated and don't have contact. Carer's support groups, but I don't think they are widely known about. I don't know how high profile these cases are. I think there has to be something.

Interviewer: But what could they get from carer's support groups?

Informant: I think that talking to other carers so they know that they're not the only ones in that particular situation. Other carers in similar situations that they can talk about issues and how they can be supported if they have any problems. Em, just to be able to,

yeah. I think peer support could be more useful just to ringing up or going out. Leaflets or something.

Interviewer: What about the research that's been done on the gender aspect of care. The fact that more women than men are involved with informal care? Why do you think that is?

Informant: I think it's because women are involved in families, nurturing, caring. They've always been the providers of care. The male's been the breadwinner and the.

Interviewer: Is that a common conception? Is that valid?

Informant: Well I think for the generation we're dealing with I think they can have these notions. It's what they've grown up with and what they've lived with but whether it's valid or not I don't know. A great deal of carers are men.

Interviewer: Do you think that women are necessarily better at caring than men?

Informant: I don't think so, no. I'm just thinking of a couple.... He's not on our caseload but he's really. And another one. Their wives have had strokes. One in particular, he's very caring. So I don't think its necessarily women would make better carers than men but they have certain qualities which enable them to care....intuitively.

Interviewer: Do you think your reaction is different to male carers than it is to women, like when you're assessing needs?

Informant: No I just go in and assess and I try not to that that influence my judgement. I try not to make judgements but it's very hard sometimes. I try to assess the situation as it is. As their needs are as a whole, rather than this thing or the next thing.

Interviewer: Do you think there are some underlying assumptions about women and their caring attitude? Is it something that is in the mind set of nursing as a whole?

Informant: Well nursing is predominately female. I think it might be in the minds of the patients. We have a male night sitter and I have to warn them, well not warn them but let them know he's a man. And it seems that as a nurse he's just the same as a woman. The gender stereotype is something to let go of.

Interviewer: Do you think that it's not just in the general population but in nursing as a whole? That are uncomfortable with male carers.

Informant: I'm not sure about that. Professionally they're just the same, male carers.

Interviewer: Lastly, how do you go about assessing a carers needs? Is there are formal system for tha?

Informant: No but that's something that has been addressed off and on. I mean there is paper work around but we don't actually use it.

Interviewer: So you rely on to a certain extent carers saying what their needs are?

Informant: You do. You rely on them saying and what you yourself think they are needing and asking appropriate questions to establish what their needs might be. You think about what you did in the past. Situations that have been similar.

Interviewer: So to a large extent you use your initiative? Is that something that you think works successfully or do you think that you should have a formal system?

Informant: Yes I think that probably we should have a formal assessment tool because not everyone asks the same questions so you're relying on tradition.

Interviewer: So really you're hoping that people are good at communicating their needs to say "I can't cope", or "I don't know what to do"?

Informant: A lot of it as well is that you know, gut feeling. You sense that things aren't quite right either. They're not willing to say or they can't say. Sometimes you just sense

something. You just take it from there. You shouldn't go in and be blinkered and do what you have to do and get out. You do a formal assessment and you're assessing all the things. You're assessing the situation.

Interviewer: And when you're assessing do you think about the cost of the resources? Do you consider the financial implications?

Informant: Yes the charges are something that they look at and when we do the initial assessment we look at the benefits they're on.

Interviewer: What about when you've got a heavy caseload and you're struggling but you see a need there in terms of meeting the needs of the patient?

Informant: Well you might be thinking that you can't do it but getting back to the benefits often services have financial implications. But if the carers not coping with getting them washed or dressed but they don't want to have to pay the Social Care Officer to come in and do that and they're not willing to do it and often the patient and the carer are struggling.

Interviewer: Does that happen very often?

Informant: Yes it does actually, yeah. It's often people who are on carers allowance but they feel that they don't want to spend it on care.

Interviewer: Do you have any recent examples of that?

Informant: No one that I can think of.

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